Printed: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				CONSTRUCTION	(X3) DATE SU COMPLE		
		175542		B. WING		09/28/2015	
	OVIDER OR SUPPLIER	DE OVERI AND DARK		ESS, CITY, STATE,			
ADVANCE	D HEALTH CARE C	OF OVERLAND PARK		DIAN CREEK I AND PARK, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	' STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS		F 000			
	The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00078397, #KS00082487, and #KS00088192.						
	483.15(b) SELF-DE MAKE CHOICES	ETERMINATION - RIGHT	ТО	F 242			
	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to honor resident preferences for when to wake up in the morning for 3 of 3 resident's sampled for choices. (#93, #248, #262)						
	Findings Included:						
	Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: pneumonia (inflammation of the lungs) and insomnia (difficulty sleeping). Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. The resident required limited to extensive assistance of one staff with ADL's (activities of daily living).						
LABORATOR					TITLE		(X6) DATE

(X2) MULTIPLE CONSTRUCTION

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175542		B. WING		09/2	09/28/2015	
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVEDI AND DADK		RESS, CITY, STA	TE, ZIP CODE K PARKWAY	•		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		AND PARK,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 242	Continued From page	e 1		F 242				
	(Care Area Assessmed documented the resident and required assistant Review of the care plat documentation regard preferences of when the mornings. The scare plan blank. Review of an activity documented the resident documented the resident laid in be eyes closed with the licare staff P entered the resident's vital signe/she was tired. The turn off the lights. Staff he/she left the room. During an observation direct care staff Q entiturned on lights, and staff Q told the resident staff Q replied he/she A.M. The resident recthan 7:00 A.M. Staff turning off the lights. the resident turned on turned or the lights.	dent had decreased mo ice of one staff with AD an dated 8/31/2015 lac	bility L's. ked p in the 2015 at 3 A.M. ket, direct took staff P to s as 7 A.M. m, signs ou up and :00 later A.M. ested					
		n on 09/21/2015 at 6:38 tered the resident's roo						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175542		B. WING		09/28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ADVANCI	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 242	and told the resident toilet. The resident's toilet and staff replied assisted the resident resident, "Can I go all since you're already "It's early" and staff restaff assisted the resident's At 7:07 A.M. the resident stated he 8:00 A.M. but staff froom at 6:00 A.M. During an interview of direct care staff W stawhy the lights were leand night staff did not them up for the day. During an interview of direct care staff S staroutine to start taking. During an interview of direct care staff Q saget up in the morning wanted to sleep in lar preference was to get up in the morning staff nurse asked the residuate to get up in the morn were technically ables.	he/she wanted him/her stated he/she did not ne d, "Let's just try". Staff to the toilet and asked head and get you dress up." The resident replie eplied, "Well, I get up a sident with dressing and hair as he/she sat in a codent sat in his/her with a blanket, in front coom. on 09/16/2015 at 5:26 Pe/she preferred to sleep requently came to his/her ated he/she was not aweft on in the resident's ret wake up residents to go on 09/17/2015 at 11:18 ated it was his/her morn	ed to the ed ed, t 5". chair. of the .M. o until er .M. d to ott s P.M. orred onts ed the	F 242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE! AND PARK,	K PARKWAY KS 66207			
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F 242	H said the resident dibreakfast, but he/she started vital signs at 6 did not mind because sleep. Staff H said he A.M. to give medication. During an interview of administrative nursing was moving towards a medication administration of wake up time. Start should wait closer to wake up time to get volumedication times. Review of the facility's	d not like to get up for would. Staff H said st 3:00 A.M. and the reside he/she just went back e/she needed vitals by ons. In 09/21/2015 at 7:14 P g staff D stated the facility station to allow for preference of the resident's preferred ital signs and the staff of to request a change in sundated Patient Directed the facility allowed eir care to the extent	ent to 7:00 .M. ity ized ences taff could	F 242				
	order sheet dated 9/1 following diagnosis: h							
	Set) dated 9/4/2015 of Interview for Mental S		rief ch					
	Review of the ADL (a	ctivities of daily living)	CAA					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
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F 242	(Care Area Assessmed documented the reside ADL's following a left Review of the care plated documented the reside and go to bed early. The care plan were for Review of an activity documented the reside 8:00 A.M. During an observation direct care staff S ent take vital signs. At 7: assist the resident with stated, "you need to take up to come get you buring an observation direct care staff X assist the resident stated here sident stated here sident stated here sident stated here how, however if he/shall the resident stated here sident stat	ent) dated 9/9/2015 dent required assistance hip replacement. an dated 8/28/2015 dent preferred to get up The options for the time r staff to mark early or I assessment dated 9/2/2 dent preferred to get up n on 09/17/2015 at 7:01 dered the resident's roor of A.M. staff S returne th getting dressed. Stathink of how early I had bu up". n on 09/21/2015 at 7:40 disted the resident with n 09/16/2015 at 5:53 P e/she preferred to sleep n 09/17/2015 at 7:06 A e/she did not want to get the wanted breakfast be the had to. n 09/21/2015 at 7:42 A e/she preferred to get up to me wanted breakfast be the had to. n 09/21/2015 at 7:42 A e/she preferred to get up to me wanted breakfast be the had to. n 09/17/2015 at 7:42 A e/she preferred to get up to me in earlier".	early es on late. 2015 at 1 A.M. m to d to aff S to O A.M. A.M. o until .M. et up fore .M. ed. up at A.M.	F 242				
	direct care staff S said	d his/her morning routir	ne					

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ADVANCED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
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F 242 Continued From page was for him/her to obta S was not aware of thi time for getting up in the During an interview on direct care staff Q said the resident's preferred. During an interview on licensed nursing staff I no problem getting up the staff started getting people up as you go." specific preference for morning. During an interview on therapy staff GG state depended on when the He/she stated the goas saw all residents and start early and some puring an interview on administrative nursing expected staff would not resident's preferred time. Review of the facility's Care policy documentaresident's to direct the possible. The facility failed to he preferred wake up time.	ain vitals at 6:00 A.M. is resident's preference the morning. In 09/21/2015 at 10:47 At the/she was not award wake up time. In 09/21/2015 at 3:36 P. H. stated the resident he early. He/she said ong vital signs "you just of Stated the resident has when to get up in the end of the therapy start time therapist wanted to sail was to make sure the some therapist preferroreferred to start later. In 09/21/2015 at 8:12 P. staff D stated he/she not take vital signs untime to get up at 8:00 A. Is undated Patient Directed the facility allowed in care to the extent one of the start later.	A.M. e of .M. had	F 242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			RESS, CITY, STA				
ADVANCI	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE! AND PARK,	K PARKWAY KS 66207			
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F 242	order sheet dated 9/1 following diagnoses: opulmonary disease (clungs), hypertension and atrial fibrillation (a). There was not an MD CAA (Care Area Asseresident did not reside to meet the criteria. Review of the care pladocumented the resident see arly and to go to options for the staff to plan were early and la. Review of the resider dated 9/14/2015 docupreferred to wake up. During an observation licensed nursing staff room to check the reshim/her insulin (a measugar levels). During an observation licensed nursing staff room to check his/her Normalized Ratio) (a the blood can clot). During an interview of the resident stated stamedications and he/s sleep. The resident stated stamedications and he/s sleep. The resident stated stamedications and he/s sleep. The resident stated stated stated stated stated stated stamedications and he/s sleep. The resident stated	4/2015 documented the chronic obstructive chronic poor airflow in the care and above the chronic poor and the care at the chronic poor and the chronic poor a	ne re), nm). and bugh s to ble e 4 A.M. 's d give d 3 A.M. 's fast .M.	F 242				

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ADVANCE	ED HEALTH CARE O	F OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207		
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	During an interview direct care staff S se 6:00 A.M. per his/he was not aware of th for getting up in the During an interview licensed nursing statime to wake up was During an interview administrative nursing was moving towards medication administ to choose his/her was he/she expected state to obtain vital signs, give medications. Review of the facility Care policy docume residents to direct the possible. The facility failed to preferred wake up to 483.15(f)(1) ACTIVI INTERESTS/NEED.	on 09/17/2015 at 11:18 aid he/she obtained vital er normal routine. Staff is resident's preference to morning. on 09/21/2015 at 4:12 Poff said the resident's press 7:00 A.M. on 09/21/2015 at 7:14 Poff said the resident's press 7:00 A.M. on 09/21/2015 at 7:14 Poff said the facility and liberal stration to allow the resident at the facility and staff D said sake up time. Staff D said aff to wait closer to 9:00 and INR's, blood sugars, and any support of the facility allowed the facility allowed their care to the extent the honor this resident's time. TIES MEET	s at S S time P.M. eferred P.M. lity ized ents d A.M. d to cted gram e with ts and	F 242			
	The facility reported 19 residents in the s	s not met as evidenced la census of 29 resident sample. Based on	s with				

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ADVANCE	ED HEALTH CARE OI	F OVERLAND PARK		OIAN CREEI AND PARK,	K PARKWAY KS 66207		
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F 248	facility failed to provi	ge 8 de an activity program e interest for 2 of 3 sam or activities. (#4, #248)	pled	F 248			
	sheet dated 9/2/2019	t #4's signed physician o 5 documented the follow c upper arm fracture (br	ving				
	Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident required extensive assistance of one staff with ambulation and locomotion on and off the unit. He/she reported it was very important for him/her to do things with groups of people.						
	Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/8/2015 documented the resident required extensive with ADL's (activities of daily living)						
		olan dated 9/11/2015 fail s's activity preferences.	led to				
	activity schedule dod scheduled weekend Saturdays: 9:00 A.M Sports Viewing or Games	st and September 2015 cumented the following activities: M. Daily Memo, 11:00 A. ames, 2:00 P.M. Movie Daily Memo, 11:00 A.M	or				

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NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
ADVANCED HEALTH CARE OF				K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
8/27/2015 through 8/3 resident attended the activities: Daily memo activity ar 8/29/2015. The reside on 8/30/2015. Review of an activity p 9/1/2015 through 9/20 resident attended the activities: Daily memo activity ar 9/19, and 9/20/2015, v 9/19, and 9/20/2015. During an observation the resident worked w room. During an observation the daily memo activity by staff at the entrance "Honey is the only foo During an interview or the resident stated the that interested him/her resident said he/she p during the week and w the weekends if the fa resident said he/she li and was not interested his/her own. The residentivities with other resocialize, but would like activities.	participation record data 1/2015 documented the following weekend and word game activity ent did not attend activity articipation record data 1/2015 documented the following weekend and word game activity word game activity on a on 09/17/2015 at 2:04 with therapy in the therapy on the chalkboard ple of the therapy room and that does not go back an 09/17/2015 at 12:02 are were not any activity on the weekends. The participated in activities would like to participated in clility offered them. The ked to socialize with own dent said he/she arrangidents to keep busy aske the facility to hold an 09/21/2015 at 1:52 Principal 1:52 Prin	ne on rities ted e 9/12, 9/12, 4 P.M. appy 1 A.M. aced read d." P.M. ties ne s e on ne thers aged and	F 248				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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ADVANCI					K PARKWAY KS 66207			
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F 248	the daily memo activitial ways read the chalk therapy gym. The reschalk board for an activities. The resident caregiver brought in cotball game last we resident's were not at big screen television gone for the day. The received crossword pwould not consider the involve other people. During an interview of direct care staff S said P.M. daily and reside activities by reading the hallways or reading a Staff S said the reside games and cards in the movies they could was buring an interview of direct care staff T said movies in the therapy. During an interview of direct care staff Q said included bible study a by the weekend receive (certified nursing assive residents wanted to see knew this resident like on the weekends and During an interview of the therapy staff HH state activity aide under the said activity aide under the control of the c	ty was and he/she did reboard when entering the sident said reading the ivity was not an activity it said his/her home chips and dip to watch the selection of the to use the therapy good because the therapy good because the therapist was resident said he/she received a	of the the typm vere never and t A.M. 00 te the the the the the the the the the	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK	4700 IN	INDIAN CREEK PARKWAY				
			OVERL	AND PARK,	KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH OF THE APPLICATION SHOUTH OF THE APPLICATION SHOUTH OF THE APPLICATION OF THE APPLI	ULD BE	(X5) COMPLETION DATE	
F 248	Continued From page 11 schedule remained the same for more than one			F 248				
F 248	schedule remained the year. Staff HH said he activities the same be cognitive issues and calendar and it was ethe same. Staff HH said he same. Staff HH said it was responsible for a wrote on the chalkboat therapy entrance and discuss it during thera resident attended the resident attended the resident liked to stay them crosswords for a He/she stated, "I just out the staff document the activity. During an interview of licensed nursing staff to play cards on the wresidents. During an interview of administrative nursing provided activities 7 comeet the individual results of the indiv	the same for more than one le/she tried to keep the ecause some residents did better with a structuration asier to keep the activities and he/she came into the one weekend day and the front desk receptionistic ctivities. Staff HH said and a memo daily at the residents who read it apy. He/she stated if the rapy, staff documented activity. Staff HH said in his/her room, staff gran individual activity. hand it out and if hand the the resident attend at the resident attend activity. It is a tasted the resident attend activity. It is a tasted the resident attend activity. It is a tasted the resident attend activity and it out and if hand the stated this resident I weekend with other and the stated the stated staff and the weekend reception activities and he/she is activities and he/she is activities and he/she is activities and he/she is activities and the therapy gym and consider requested. Stated ide group activities to the stated activities activitie	had ured ties the the st staff star the diff a lave led led led liked li	F 248				
	Review of the Activity	Program Policy dated						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IN	RESS, CITY, STATE DIAN CREEI AND PARK,	K PARKWAY		
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F 248	1/10/2011 documented program was designed interests and physical well-being of each pacalendar of events was individual interest and The facility failed to p	ed an ongoing activities ed to meet the individua I, mental, and psychoso tient and each month a as designed to meet the	ıl ocial ı	F 248			
	order sheet dated 9/1 following diagnosis: It depression (an abnor characterized by feeli worthlessness, emption of the admission of the admis	amal emotional state ings of sadness, ness and hopelessness sion MDS (Minimum Da documented a BIMS (Br Status) score of 15, whice tion. The resident requi of one staff with walking the unit. He/she report to him/her to do things we activities of Daily Living) ent) dated 9/9/2015 dent required assistance	s). ta rief ch nired g and rted it ith				
	address the resident's activities. Review of the August	hip replacement. an dated 9/15/2015 failes personal preferences and September 2015 umented the following					

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ADVANCED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
Sports Viewing or Gar Games Sundays: 9:00 A.M. It Sports Viewing Review of the August activity schedule reverse scheduled after 3:45 Fractivities scheduled in Review of an activity provided the activities: Daily memo and word 8/30/2015. He/she did weekend activities. Review of an activity provided the activities. Daily memo activity and 9/19, and 9/20/2015, provided the activities. During an observation the resident laid in his family member. During an observation the daily memo activity at the entrance of the is the only food that delivered the activities and the only food that delivered the activities and provided the activities.	activities. Daily Memo, 11:00 A. mes, 2:00 P.M. Movie Daily Memo, 11:00 A.M. and September 2015 aled there were no act P.M. There were no a the evenings. participation record data 31/2015 documented the following weekend d not attend any evening participation record data 0/2015 documented the following weekend and word game activity word game activity word game activity on He/she did not attend an on 09/16/2015 at 5:56 sher bed visiting with a con 09/21/2015 at 6:20 ty on the chalkboard by therapy room read "He	or I. ivities ivities ded ee 9/12, 9/12, any 9 P.M. 1 A.M. v staff oney	F 248				

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA				
				DIAN CREE! AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 248	calendar when he/she receive an activity cal September. The resit to go to activities if acconvenient to attend a evening and weekend. During an interview of the resident stated he the daily memo activities word games. During an interview of direct care staff S said P.M. daily and reside activities by reading the hallways or a calendary said the resident's hallways or a calendary in the library they could watch in the direct care staff T said movies in the therapy. During an interview of direct care staff Q said included bible study aby the weekend receive (certified nursing assist residents wanted to sknew this resident like on the weekends and During an interview of the therapy staff HH states activity aide under the director. He/she states schedule remained the service of the states activity aide under the director. He/she states schedule remained the service of the states activity aide under the director. He/she states activity aide under the director.	e first admitted and did lendar for the month of dent said he/she would ctivities were more and if he/she knew of d activities. In 09/21/2015 at 1:50 Pe/she was not aware of the description of the screen located in the ar provided weekly. Stave access to board garry room, as well as mover in 09/17/2015 at 2:46 Pe/d the facility had weeked gym. In 09/21/2015 at 10:38 and activities on the weeked activities on the weeked activities on the weeked activities on the weekend grant of the control of the control of the control of the weekends, and playing cards organizationist or the CNA's stants). Staff Q said in leep on the weekends, and to participated in activities on activities on the weekends, and the participated in activities on the weekends, and to participated in activities on the weekends.	Iike .M. what not A.M. 00 the eff S nes vies .M. end A.M. cends nized nost but ivities A.M. o y r one	F 248				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDE	RESS, CITY, STA	TE. ZIP CODE	I		
	ED HEALTH CARE OF	OVEDI AND DADK			K PARKWAY			
				AND PARK,				
				AND I AITH,	10 00207		T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 248	Continued From pag	e 15		F 248				
Γ 240	activities the same be cognitive issues and calendar and it was e the same. Staff HH stacility for 6 hours on other weekend day the was responsible for a daily memo was a sachalkboard placed at residents who read it therapy. He/she state therapy, staff docume the activity. Staff HHiked to stay in his/hel crosswords for an indicated, "I just hand it of the constitution of the constitu	ecause some residents did better with a structurasier to keep the activities aid he/she came into the one weekend day and the front desk receptionist ctivities. Staff HH said ying staff wrote on the the therapy entrance a may discuss it when do the diff the resident attendented the resident attendented the resident State of room, staff gave them invidual activity. He/she out" and if handed out the resident attendented the resident attendented the resident attendented the resident attendented the resident attended the resident attended the resident attended the	ared ties the the tthe st the oing ded ded ed	F 240				
	licensed nursing staff aware of the resident activity involvement. During an interview of administrative nursing provided activities 7 comeet the individual restated he/she consided 3:00 P.M. were even in During an interview of administrator A stated coordinated weekend worked from 9:00 to 8 nurses had a key to that access the gym if a residential access.	n 09/21/2015 at 7:43 P If the weekend reception activities and he/she 5:00 P.M. Staff A said the therapy gym and co esident requested. Stafide activities to the resi	.M. lity hould taff D d at .M. nist					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175542		B. WING			8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
				DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 248 F 279 SS=D	Review of the Activity 1/10/2011 documente program was designe interests and physical well-being of each pacalendar of events was individual interest and The facility failed to pactivities to meet the 483.20(d), 483.20(k)(Program Policy dated ed an ongoing activities ed to meet the individual, mental, and psychosotient and each month a as designed to meet the dineeds. Tovide weekend and evinterests of this resider 1) DEVELOP	ocial	F 248				
SS=D	A facility must use the to develop, review an comprehensive plan of the facility must develop plan for each resident objectives and timetal medical, nursing, and needs that are identificances assessment. The care plan must do to be furnished to attain highest practicable proposed proposed plan for each resident's expense of the facility reported and the total plan for the facility reported and the facility reported and comprehensive facility facili	e results of the assessed revise the resident's of care. elop a comprehensive of that includes measurables to meet a resident mental and psychosocied in the comprehensive escribe the services that in or maintain the resident or maintain the residence that would otherway as required under vices that would otherway. Such a treatment of the residence of rights under the right to refuse treatment of the residence	care able 's cial ve at are dent's vise ded -					
	19 residents in the sa observation, interview		e					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175542		B. WING		09/2	09/28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
				DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	1 0	e 17 ent's reviewed. (#4, #24	.8,	F 279				
	Findings Included:							
	- Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnoses: traumatic upper arm fracture (broken bone)							
	Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident required extensive assistance of one staff with ambulation and locomotion on and off the unit. He/she reported it was very important for him/her to do things with groups of people.							
	Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/8/2015 documented the resident required extensive with ADL's (activities of daily living)							
		an dated 9/11/2015 fails s activity preferences.	ed to					
	activity schedule docu scheduled weekend a Saturdays: 9:00 A.M Sports Viewing or Ga Games Sundays: 9:00 A.M. I Sports Viewing	and September 2015 umented the following activities: Daily Memo, 11:00 A.I mes, 2:00 P.M. Movie Daily Memo, 11:00 A.M	or					
	,	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER			1	CONSTRUCTION	(X3) DATE SUF COMPLET	
	175542		B. WING		09/2	8/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE	OF OVERLAND PARK	4700 IN	RESS, CITY, STATE DIAN CREEK AND PARK, K	PARKWAY		
PRÉFIX (EACH DEFICIENCY	RY STATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL RE SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
resident attended activities: Daily memo activities: Daily memo activities: Neview of an activities: Paily memo activities: Daily memo activities: During an observathe resident workeroom. During an observathe daily memo activities the entivities the entivities the entivities the entivities that interested hir resident said he/s during the week at the weekends if the resident said he/s and was not interhis/her own. The activities with othe socialize, but wou activities. During an interviet the resident said interviet th	h 8/31/2015 documented to the following weekend ity and word game activity esident did not attend activity participation record da 9/20/2015 documented the the following weekend ity and word game activity in 15, word game activity on	on vities ted e 9/12, 9/12, 9/12, 4 P.M. apy 1 A.M. laced read d." P.M. ties The s e on ne others and	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
175542 B. WIN			B. WING	G09/28/2015		
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
ADVANCED HEALTH CARE OF OV	VERLAND PARK		DIAN CREEK AND PARK,	K PARKWAY KS 66207		
PREFIX (EACH DEFICIENCY MUST BE	EMENT OF DEFICIENCIES E PRECEDED BY FULL REC IFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279 Continued From page 19 always read the chalkboot therapy gym. The resident chalkboot therapy gym. The resident sat caregiver brought in chip football game last weeker residents were not able to big screen television bedgone for the day. The reserved crossword puzz would not consider this at involve other people. During an interview on Office direct care staff S said at P.M. daily and resident wactivities by reading the shallways or reading a call Staff S said the resident games and cards in the I movies they could watch. During an interview on Office direct care staff T said the movies in the therapy gy. During an interview on Office direct care staff Q said at included bible study and by the weekend reception (certified nursing assistant residents wanted to sleet knew this resident liked to on the weekends and du. During an interview on Office the staff HH stated heactivity aide under the did director. He/she stated schedule remained the staff chalked to shedule remained the staff chalked to schedule remained the staff chalked the schedul	ard when entering the ent said reading the y was not an activity aid his/her home os and dip to watch the end, but was told the to use the therapy gy cause the therapist we esident said he/she rizles or word games a can activity if it did not series began at 3:0 would know about the screen located in the elendar provided week had access to board library room, as well in their rooms. 19/17/2015 at 2:46 P. The facility had weeke with the elendar provided week with the playing cards organ onist or the CNA's antis). Staff Q said me pon the weekends, to participate in activiting the week.	of he ym vere never and t A.M. 00 e e ekly. d as .M. nd A.M. tends ized host but vities	F 279			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE S COMPL		
		175542		B. WING		09	/28/2015
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE O	F OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 279	year. Staff HH said activities the same I cognitive issues and calendar and it was the same. Staff HH facility for 6 hours of other weekend day was responsible for wrote on the chalkby therapy entrance and discuss it during the resident attended the resident attended the resident liked to state them crosswords for He/she stated, "I just out, the staff document the activity. During an interview licensed nursing state to play cards on the residents. During an interview administrative nursing provided activities 7 individual resident planned. Review of the undare plan to ensure the repracticable physical well-being. The facility failed to	he/she tried to keep the because some residents did better with a structure asier to keep the activities and he/she came into an one weekend day and the front desk receptionic activities. Staff HH said oard a memo daily at the first desidents who read it the erapy. He/she stated if the erapy, staff documented the activity. Staff HH said y in his/her room, staff gran individual activity. It hand it out and if hand the end of the resident attendance on 09/21/2015 at 12:59 aff H stated this resident weekend with other on 09/21/2015 at 7:42 Pang staff D stated staff days a week, meet the preferences, and be care the facility developed a desident reached the high, mental, and psychosocicare plan individual activities and the weekend with owned to care plan individual activities and the weekend with owned to care plan individual activities and the weekend with owned to care plan individual activities and the care plan	had ured ties the the st staff e ine if the dif a ave ded ded P.M. liked	F 279			

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 21 F 279 - Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279 Continued From page 21 F 279 F 279		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				(X3) DATE SU	
ADVANCED HEALTH CARE OF OVERLAND PARK 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 21 F 279 - Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state)			175542		B. WING		09/28/2015	
OVERLAND PARK, KS 66207 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 21 - Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state)								
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 21 F 279 - Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279 Continued From page 21 F 279 F 279	ADVANCE	ED HEALTH CARE OF	OVERLAND PARK					
- Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state	F 279	Continued From page	e 21		F 279			
characterized by feelings of sadness, worthlessness, emptiness and hopelessness). Review of the admission MDS (Minimum Data Set) dated 9/4/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with walking and locomotion on and off the unit. He/she reported it was very important to him/her to do things with groups of people. Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/9/2015 documented the resident required assistance with ADL's following a left hip replacement. Review of the care plan dated 9/15/2015 failed to address the resident's personal preferences for activities. Review of the August and September 2015 activity schedule documented the following scheduled weekend activities. Saturdays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing or Games, 2:00 P.M. Movie or Games Sundays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing Review of the August and September 2015 activity scheduled after 3:45 P.M. There were no		- Review of residents order sheet dated 9/1 following diagnosis: It depression (an abnor characterized by feeli worthlessness, emption Review of the admiss Set) dated 9/4/2015 of Interview for Mental Sindicated intact cognities extensive assistance locomotion on and off was very important to groups of people. Review of the ADL (A (Care Area Assessmed documented the resident's activities. Review of the care planddress the resident's activities. Review of the August activity schedule docuscheduled weekend a Saturdays: 9:00 A.M. Sports Viewing or Ga Games Sundays: 9:00 A.M. I Sports Viewing Review of the August activity schedule revealed the review of the August activity schedule revealed the revealed the August activity schedule revealed the August activity schedule revealed the revealed the August activity schedule revealed the revealed the revealed the August activity schedule revealed the revealed	#248's signed physician /2015 documented the hip replacement and mal emotional state ings of sadness, ness and hopelessness sion MDS (Minimum Dadocumented a BIMS (Bistatus) score of 15, whition. The resident required of one staff with walkin fithe unit. He/she report him/her to do things whick tivities of Daily Living ent) dated 9/9/2015 dent required assistance hip replacement. an dated 9/15/2015 fails a personal preferences and September 2015 umented the following activities. Daily Memo, 11:00 A.M. Daily Memo, 11:00 A.M. Daily Memo, 11:00 A.M. and September 2015 ealed there were no activities and September 2015 ealed the eal	ta rief ch iired g and rted it iith CAA e with ed to for M. or				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	•		
				DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 279	Continued From page	e 22		F 279				
	activities scheduled in	n the evenings.						
	8/29/2015 through 8/3 resident attended the activities: Daily memo and word	-	ne					
	Review of an activity participation record dated 9/1/2015 through 9/20/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity 9/12, 9/19, and 9/20/2015, word game activity on 9/12, 9/19, and 9/20/2015. He/she did not attend any evening activities.							
	During an observation on 09/16/2015 at 5:59 P.M. the resident laid in his/her bed visiting with a family member.							
	the daily memo activit	n on 09/21/2015 at 6:21 ty written by staff on the rance of the therapy roo ly food that does not go	e om					
	the resident stated stated and calendar when he/she did not receive an act of September. The relike to go to activities convenient to attend a evening and weekend		ivity she onth uld					
	-	e/she was not aware of	I					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175542		B. WING		09/:	28/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	-	
ADVANCED HEALTH CARE OF C		DIAN CREE AND PARK,	K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY MUST				PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279 Continued From page the daily memo activity receive word games. During an interview on direct care staff S said P.M. daily and resident activities by reading the hallways or a calendar said the residents have and cards in the library they could watch in the During an interview on direct care staff T said movies in the therapy of the weekend recept (certified nursing assist residents wanted to sle knew this resident liked on the weekends and of the director. He/she state activity aide under the director. He/she state schedule remained the year. Staff HH said he activities the same bed cognitive issues and di calendar and it was ea the same. Staff HH said he was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible and the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the same was responsible for activity memo was a sayi chalkboard placed at the	y was and he/she did responsible to the provided weekly. State access to board game y room, as well as mover rooms. 1 09/17/2015 at 2:46 Power rooms. 1 09/17/2015 at 2:46 Power rooms. 1 09/17/2015 at 10:38 And the provided weekly stants access to board game y room, as well as mover rooms. 1 09/17/2015 at 10:38 And the provided weekly stants acceptant of the CNA's stants. Staff Q said neep on the weekends, at the provided weekly stants acceptant of the theraped the activity calendary and the provided weekly stants acceptant of the theraped the activity calendary as a provided weekly stants acceptant to keep the cause some residents and better with a structural state to keep the activities and he/she came into the provided weekly staff wrote on the structure of the state of the activities. Staff HH said ing staff wrote on the	A.M. 00 t the e aff S nes vies .M. end A.M. kends nized most but vities A.M. n by r one had ured ties the the st the	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175542		B. WING	 	09/2	8/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ADVANCI	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	residents who read it therapy. He/she state therapy, staff docume the activity. Staff HI-stay in his/her room, for an individual activity hand it out" and if har documented the resident activity involvement. During an interview or licensed nursing staff aware of the resident activity involvement. During an interview or administrative nursing provided activities 7 cmeet the individual restated he/she consided 3:00 P.M. were evenificativity preferences so Review of the undate Policy documented the plan to ensure the respracticable physical, it well-being. The facility failed to compreferences for this reparticipate in activities. Review of the close physician order sheet documented the followartery disease (heart	may discuss it during and if the resident attendent the resident attendent a	ded to ords st ty. P.M. ot or .M. ity hould aff D d at aid e Plan care est ial rity	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
	175542		B. WING		09/2	09/28/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
Review of the admission Set) dated 7/22/14 doc a BIMS (Brief Interview of 8, which indicated mimpairment. The residuassistance for bathing assistance with the baren Review of the of ADL (documentation dated 2014 recorded staff as shower on 7/19/15 and shower on 7/30/15. During an interview on direct care staff Y state the night shift if a residuant residents for bathing to have additional shower stated if a resident refundred with the resident refundred nursing assistants) gardid not review the documentation dated. During an interview on direct care staff V state residents for bathing to have additional shower stated if a resident refundred know and then on the state of the staff I as shower twice a week requested. Staff I said nursing assistants) gardid not review the documentation that the resident if the puring an interview on administrative nursing have showered the resident refundred there was not a showered the resident refundred the resident refundred there was not a showered the resident refundred the resident refundred there was not a showered the resident refundred the refundred	on MDS (Minimum Dacumented the resident of for Mental Status) so moderate cognitive dent required physical transfers and set upothing task. (Activities of Daily Living July 2014 through Augustisted the resident with different refused of the resident refused of the she gave showed dent requested, but state of the facility schedule wice a week, but they were if requested. Staffing used bathing, staff let documented the refused of the CNA's (certified the CNA's (certified the Showers and he umentation. He/she and showers and the staff D stated staff she staff D stated She staff D	ng) just th one a M. ers on aff did ght M. ed could V the al. M. ived she sked alked M. ould d	F 279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 279	showered the resident refusal. During an interview of nursing staff D confirm address bathing. Review of the undate Policy documented the care plan to ensure the highest practicable playschosocial well-being refusal.	nt and one documented in 9/21/2015 administra med the care plan failed d Comprehensive Care he facility staff develope he resident reached the hysical, mental, and	tive d to e Plan ed a	F 279			
	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to provide the necessary care and services for 3 or 3 sampled residents reviewed		F 309				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	175542			B. WING		09/2	09/28/2015	
	VIDER OR SUPPLIER			ESS, CITY, STA				
ADVANCE	D HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	order sheet dated 9/1 following diagnoses: replacement and eder There were no MDS (CAAs (Care Area Ass because the resident's not met. Review of the care pladocumented a skin te abrasions on his/her fhis/her left knee. State 9/9/2015 and included directed staff to apply arm, Geri sleeves (fath from injury), ensure his in bed, and tubigrips (both lower legs. Review of a physician of the farm and device used to elevate resident's heels. Review of physician of following: Geri sleeves to preven 9/9/2015 During an observation the resident did not wear heels were not elevate corner of the room.	#254's signed physician 1/2015 documented the aftercare following a known (swelling). Minimum Data Sets) and sessments of this residual to the resident's left forehead and steri-stripment of the care planed and the care planed and the care planed and the care planed and the care planed the care planed to the resident of the care planed and the care planed and the care planed the care planed to the care planed the care planed to the care planed to the care planed to the care planed the progress note dated at the resident had a skill added a heel riser (and the care documented the care documented the care documented the care documented the care possession of the care documented the care documented the care and the care documented the care and the car	e nee nee nee nee nee nee nee nee nee n	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175542		B. WING		09/2	8/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCED HEALTH CARE OF (OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309 Continued From page the resident sat in his/I staff Q assisted the reshis/her tubigrips and subruising to the left inner not wear Geri sleeves. During an observation the resident laid in bed against the footboard. not elevated and he/sh Geri-sleeves. The heat the room During an observation the resident laid in bed heels were not elevated Geri-sleeves. The heat the room. During an interview on resident stated he/she by an enlarged spleen stated he/she used his time last night and staff wear anything to prote resident stated he/she sleeves were. During an interview on direct care staff Q state riser he/she used at ni During an interview on direct care staff S state resident had bruising, interventions to protect heel rise to decrease so During an interview on licensed nursing staff in the state of the st	ther recliner and direct sident with removal of ocks. The resident has a her heel. The resident of on 09/17/2015 at 2:07 di with his/her feet president's heels in edid not wear all riser laid in the corner on 09/21/2015 at 6:19 di awake. The resident and he/she did not vel riser laid in the corner on 09/17/2015 8:00 A.M. had many bruises can at 2:09 P.M. the resident heel riser for the fidid not instruct him/lefe this/her arms. The was not aware what 0 on 09/17/2015 at 9:26 A heed the resident had a light to elevate the heel of 09/17/2015 at 11:27 and he/she unaware if the Staff S stated current at skin included the use swelling.	ord did did did did did did did did did d	F 309				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	175542			B. WING		09/2	09/28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 309	bruising to both of his his/her left forearm, a foot, and he/she wore reported the resident today because of resi was unaware if the rebed. During an interview of administrative nursing expected staff to ensisteeves and used a high physician and care placed for healing.	s/her arms, a skin tear to bruise to his/her left in a Geri sleeves. Staff H did not wear Geri sleeves ident confusion and here ident used a heel rise on 09/21/2015 at 8:13 P g staff D said he/she ure the resident wore Greel riser as ordered by lanned. But Weekly Skin Report parameter interventions were sensure the resident worker is sleeves were and us	ner ves /she or in .M. Geri the	F 309				
	order sheet dated 9/1 following diagnoses:	#259's signed physicia 15/2015 documented th chronic obstructive poor airflow in the lungs	e					
	CAA's (Care Area Ass length of stay criteria Review of the care pl							
	his/her left arm and b	ruising to his/her left ar extremities. Staff revis						

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	` '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	175542		B. WING		09/	28/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STAT	E, ZIP CODE			
ADVANCED HEALTH CARE	OF OVERLAND PARK		DIAN CREEK AND PARK, I				
PRÉFIX (EACH DEFICIENCY !	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
resident wore Ger the skin) daily. During an observathe resident sat in dark scattered bruand wore no Geri During an observathe resident sat in scattered bruising wore no Geri sleether stated bruising. The resident stated bruising. The resident stated bruising. The resident stated protectors and was wear them. During an interviether esident stated protectors and was wear them. During an interviether care staff Sthe resident had be protect his/her skin buring an intervieticare staff Q stated skin issues or skin bruising to both ar arm. Staff H repoplace to protect the dressing changes	At the continued of the	A.M. add ans D.P.M. add d.M. cher d. A. M. c	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA				
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	Geri sleeves. Staff H not wear Geri sleeves he/she had Geri sleeve nurse he/she did not During an interview of administrative nursing expected staff to ensure sleeves and stated it responsibility to ensure Review of the undate documented the nurse facility placed appropility placed for healing.	confirmed the resident is and asked the resider wes. The resident told thave Geri sleeves. In 09/21/2015 at 8:16 Postaff D stated he/sheure the resident wore G	nt if the .M. Geri place. policy	F 309				
	order sheet dated 9/1 following diagnoses: of mellitus (when the both made enough insulin, and cellulitis (a skin in redness, heat, and switcher was no MDS (I (Care Area Assessmellength of stay criteria During an observation the resident's had his and noted a small bluthis/her left lower leg.	#262's signed physician 4/2015 documented the edema (swelling), diabed dy could not use glucos or respond to the insula fection which may have velling caused by bacte Minimum Data Set) or Cent) because the reside was not met. In on 9/15/2015 at 1:59 /her lower pant leg pull- dish quarter sized bruise on on 09/17/2015 at 7:27	e etes se, lin), e eria). CAA's ent's P.M. ed up et to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/	28/2015	
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IN	RESS, CITY, STA DIAN CREE! AND PARK,	K PARKWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	licensed nursing staff assisted the resident bed to a bedside comrevealed two small quanthe resident's left low. During an observation the resident had two spurple bruises to his/full During an interview of the resident stated her bruises to his/her leg stated the facility chesince he/she took Compuring an interview of direct care staff S statinformed of medication bruising, but were expurising occurred. Statinformed of medication bruising on this resides bruising to the resident had on 9/11/2015 with no skin assessment on State bruising to the resides bruising an interview of the resides bruising the r	K and direct care staff with a transfer from his imode. Observation parter sized purple bruiser leg. In on 09/21/2015 at 4:21 small quarter sized dark her left lower leg. In 09/16/2015 at 6:13 Pershe was not aware hose occurred. The resident cked his/her labs routin umadin (a blood thinner on 09/17/2015 at 11:32 at ted all nursing staff were ons, which could cause pected to notify the nurstaff S was unaware of ent. In 09/17/2015 at 2:53 Peted he/she asked reside and if they did, he/she es. Staff T was unaware ent. In 09/21/201 at 3:47 P.M. It stated the resident his sues on admission. Start her side of the sues on admission. Start his sues on admission his sues on admission. Start his sues on admission his sues on admission. Start his sues on admission his sues on admi	ses to 1 P.M. k 1.M. by the t hely r). A.M. re not easy se if 1.M. ent's and e of M. had taff H ment and a ing the	F 309				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER				CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		175542		B. WING		09/	/28/2015		
	ROVIDER OR SUPPLIER ED HEALTH CARE (OF OVERLAND PARK	4700 IN	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 310	expected staff to ic assessment and to Review of an unda documented the no weekly skin report related conditions appropriate interve The facility failed to bruising to this resi during a weekly sk 483.25(a)(1) ADLS	dentify bruising during the ocomplete an incident reparted Weekly Skin Report Furse manager completed on all residents with skin and ensured staff had entions in place. o identify and follow up or ident's left lower extremity	Policy a	F 310					
SS=D	Based on the compresident, the facility abilities in activities unless circumstant condition demonst unavoidable. This to bathe, dress, an ambulate; toilet; ea or other functional This Requirement The facility reporte 19 residents in the and record review	prehensive assessment of y must ensure that a residence of daily living do not diminate that diminution was includes the resident's at ad groom; transfer and at; and use speech, languicommunication systems. It is not met as evidenced to a census of 29 resident example. Based on intervation to 1 of 1 residents samples thing (#263)	dent's hinish hical bility hage, by: ts with view de the						
	Finding Included:	aumig. (#200)							
	physician order sh	ed record for resident #26 eet dated 8/8/2014							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175542				09/2	09/28/2015	
NAME OF PROVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ADVANCED HEALTH CARE	OF OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207			
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
of apprehension, use and depression (feworthlessness, and Review of the adm Set) dated 7/22/14 a BIMS (Brief Intersof 8, which indicate impairment. The reassistance for bath assistance with the Review of the of Aldocumentation dat 2014 recorded statishower on 7/19/15 shower on 7/30/15 During an interview direct care staff Y sthe night shift if a resident shower resider shift. During an interview direct care staff V stresidents for bathin have additional she stated if a resident nurse know and strefusal. During an interview licensed nursing stated a shower twice a werequested. Staff I nursing assistants did not review the stated in the r	art disease), anxiety (feeligen art disease), anxiety (feeligen art disease), and irrational relings of sadness, and emptiness). All disease (Minimum Date documented the resident view for Mental Status) seed moderate cognitive esident required physical ning transfers and set up to bathing task. DL (Activities of Daily Livited July 2014 through Aug ff assisted the resident with and the resident refused	fears), ata t had t had core ng) gust th one a M. ers on aff did ght M. ed could V the M. eived /she eixed	F 310				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 310				F 310				
	with the resident if the	ey refused.						
	administrative nursing have showered the reconfirmed thee was n	n 9/21/2015 at 6:16 P.Ng staff D stated staff sho esident twice weekly and to documentation staff at and one documented	ould d					
	The facility failed to p requested.	rovide a bathing policy	as					
	The facility failed to ensure this cognitively impaired resident received adequate bathing.		J .					
F 315 SS=D	483.25(d) NO CATHE RESTORE BLADDER			F 315				
	resident who enters the indwelling catheter is resident's clinical concatheterization was now ho is incontinent of the treatment and services.	ity must ensure that a	at nt priate ct					
	The facility reported a 19 residents in the sa observation, interview facility failed to provid restore as much blade	not met as evidenced be a census of 29 residents ample. Based on w, and record review the le care and services to der function as possible wed for incontinence.	e for					
	Findings Included:							

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA		•		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	5 Continued From page 36			F 315				
	- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: recent hysterectomy (removal of the uterus, a female reproductive organ) and pneumonia (an inflammation of the lungs). Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which							
	indicated the resident had intact cognition. He/she did not reject cares. The resident required extensive assistance of one staff with bed mobility, transfers, and walking and limited assistance of one staff with toileting. The resident was frequently incontinent of urine and bowel and had no toileting program.							
	Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/10/2015 documented the resident had decreased mobility following a hysterectomy and he/she required assistance of one staff with ADL's.							
	Review of the Urinary Incontinence CAA dated 9/10/2015 documented the resident required assistance with toileting, had frequent urinary incontinence, a history of a prolapsed bladder (the bladder dropped down) and he/she notified staff for toileting needs.		l y er					
	Review of the care plan dated 8/31/2015 documented the resident was incontinent and required assistance of one staff with toileting. The care plan directed staff to assist the resident with toileting upon rising, between meals, at bedtime, and as needed. Staff revised the care plan on 9/16/2015 following a fall and directed staff to assist the resident with toileting upon rising, between meals, and at bedtime.							

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SU COMPLE	
	175542			B. WING		09/	28/2015
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 315	5 Continued From page 37			F 315			
F 315	Review of a bowel ar 9/3/2015 documente incontinent for years Staff were to assist it upon rising, before a bed. Review of the physic following: Furosemide (a medic swelling, which incre (milligrams) by mouth During an observation direct care staff O as bed using extensive resident to use his/he bed to the wheelchair resident to the dining bathroom assistance. During an observation staff P provided extensions and limited the bathroom. The mand he/she smelled is the bathroom and beginning an observation direct care staff Q enturned on lights and its Staff Q did not offer to toileting after he/she	and bladder assessment d the resident was and voided 3-4 times a ne resident with toileting and after meals, and befin an orders documented eation used to decrease ased urine output) 20 m and daily for edema, 9/10/2015 at 5:22 sisted the resident out assistance and cued the walker to transfer from an on 09/17/2015 at 8:00 msive assistance with assistance with assistance with assistance with walking esident's brief was soiled strongly of urine. In on 09/21/2015 at 6:00 tered the resident's vital of assist the resident with walking the sident's resident's vital of assist the resident with worker the resident with worker the resident.	day. Gore the the 2015. 7 P.M. of e m the r 1 A.M. sto	F 315			
	During an interview on 09/16/2015 at 5:16 P.M. the resident stated he/she slid out of bed twice when trying to take him/herself to the bathroom. The resident believed he/she turned on the call light both times for staff assistance and no staff came. The resident said the only times he/she						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE		
	175542			B. WING		09/28	3/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	attempted to walk by when staff failed to re The resident stated the know he/she needed. During an interview of the resident stated state the resident stated state resident with toile. During an interview of direct care staff S state at toileting schedule. During an interview of direct care staff T state continent of urine, use assistance as he/she set toileting schedule. During an interview of direct care staff Q state resident every 2 hourn needled to toilet. State not on a specific toileting asked about toileting resident used his/her. During an interview of licensed nursing staff on a toileting schedule and bedtime, required wore a brief for incontinuity of the program. Staff D state program. Staff D state program for every incontinuity and the state of t	him/herself was to toile spond to his/her call light alarm was to let the to go to the bathroom. In 09/21/2015 at 1:47 Paff did not routinely assting until he/she fell. In 09/17/2015 at 11:13 ated the resident was not on 09/17/2015 at 2:36 Pated the resident was not determined by the call light for needed, and was not on 9/21/2015 at 10:30 At ted staff checked on the sand asked if he/she ff Q stated the resident ting schedule so he/she every 2 hours and whe call light. In 09/21/2015 at 12:17 In stated the resident was not go to the call light. In 09/21/2015 at 12:17 In stated the resident was no on 09/21/2015 at 12:17 In stated the resident was no on 09/21/2015 at 12:17 In stated the resident was no on 09/21/2015 at 6:57 Pag staff D stated he/she staff to read the care plant in the care plan	ght. staff I.M. sist A.M. ot on I.M. on a I.M. or was en the P.M. was heals, hand I.M. an to hand	F 315			

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	28/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 315	stated the resident be 9/16/2015 following h unsure if the resident many falls occurred b Review of an undated assessment documer develop an individual resident's with cognitis become continent. The facility failed to p Incontinence Policy a individualized toileting	egan a toileting schedul is/her fall. He/she was was incontinent, but kneed to bowel and bladder need facility staff would ized toileting plan for twe abilities and motivatorovide a Urinary is requested.	new ds.	F 315			
F 323 SS=D	resident with bladder incontinence. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 29 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide supervision to prevent falls for resident (#93), failed to provide appropriate safety equipment for 2 residents (#248 and #255) all reviewed for accidents. The		F 323				
	(#248 and #255) all re		The				

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
	D HEALTH CARE OF	OVERI AND PARK			K PARKWAY			
				AND PARK,				
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page 40			F 323				
	Findings included:							
	- Resident #255 clinical record noted the resident had a diagnosis of right hip abscess. The resident was admitted to the facility 9/8/15.							
	The impaired bed mobility care plan dated 9/9/15 noted the resident utilized lateral support bed canes on the left and right side of the bed. The staff educated the resident on the potential risks and benefits as well as the proper use of the above specified device. A safety assessment was preformed regarding the use of the bed canes and the resident demonstrated appropriate use of the bed canes. The bed canes were properly installed including the elimination of entrapment zones. The bed canes would be routinely assessed during cares for proper installation and positioning. Staff would promptly report concerns to the maintenance/therapy staff for immediate							
	resolution. The physician's order bed canes for bed mo	dated 9/9/15 new orde bbility.	er for					
	The physician's order dated 9/17/15 order for bed cane to left side of bed for mobility.		r bed					
	The side rail consent form dated 9/9/15 listed potential benefits and potential risks and was signed by the resident for reason of increased independence with bed mobility.		s					
	The side rail utilization assessment date 9/9/15 noted the resident used right and left bed canes.							
	The side rail consent	form dated 9/17/15 not	ed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				` '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	1 3			F 323				
	potential benefits, risks, and was signed by the resident for reason increased independence with bed mobility. The side rail utilization assessment dated 9/17/15 noted the resident used a left bed cane. On 9/15/2015 at 4:03 P.M. the resident's bed had							
	On 9/15/2015 at 4:03 P.M. the resident's bed had bed canes on both sides of the bed. The left side bed cane had an opening of 11.5 inches by (x) 15 inches. The right side bed care had an opening of 11.5 inches x 11 inches. The resident stated he/she had to sign a form to be able to use the bed canes. The staff told him/her that he/she could be hurt using them. He/she did not have a problem with the rails and used them to help her get out of bed.							
	On 9/16/2015 at 5:48 bed, had bed canes of	P.M. the resident laid in both sides of bed.	n					
	On 9/17/2015 at 7:55 A.M. the resident ambulated in his/her room independently with a front wheel. He/she sat down in the recliner. He/she stated he/she did not have his/her arm or leg tangled in the bed canes. On 9/16/2015 at 5:51 P.M. direct care staff U stated he/she the bed canes were used for bed mobility. The resident had a left bed cane.							
			-					
	On 9/17/2015 at 8:05 A.M. direct care staff S stated resident #255 had right and left side bed canes. He/she had not seen a resident get a body part get stuck in them.		ed					
	On 9/21/15 at 5:56 P.M. direct care staff V stated the resident use the rail to help them turn in bed and be more independent.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PROVIDER OF	SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ADVANCED HEAL	TH CARE OF	OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207			
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F 323 Continu	3 Continued From page 42			F 323				
On 9/21 resident On 9/17 staff DJ mobility large op On 9/17 staff D a canes b measure side, an side. The faci canes. The faci canes. The faci canes. The faci large or canes. The faci canes. The faci canes. Review order sh following (removal inflamm Review Set) dat Interview indicate He/she required bed mol assistant resident balance mobility of urine The resi	/15 at 5:50 P. used the bed /15 at approx stated the rei. Resident havenings on his decknowledged oth sides of bements of 11 dopening of lity failed to public diagnoses: all of the admission of the luctuation of the set diagnoses: all of the admission of the luctuation of the luctu	a.M. licensed staff I stated can for mobility. Simately 7:49 A.M. licens sidents had bed canes of the black bed with opening and the black bed with opening and the black black bed with opening and the black bla	sed for with ursing d eft right for ta rief ch ith ted efor inent ram. 6					

Printed: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SUF COMPLET	
175542 B. WING 09/28/201					B. WING		09/2	8/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	IAME OF PRO	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCED HEALTH CARE OF OVERLAND PARK 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207	ADVANCEI	ED HEALTH CARE OF	F OVERLAND PARK					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG OR LSC IDENTIFYING INFORMATION) DEFICIENCY ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	OULD BE	(X5) COMPLETION DATE
F 323 falls since admission. Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/10/2015 documented the resident had decreased mobility following a hysterectomy and he/she required assistance of one staff with ADL's. Review of the Urinary Incontinence CAA dated 9/10/2015 documented the resident required assistance with toileting, had frequent urinary incontinence, a history of a prolapsed bladder (the bladder drops down) and he/she notified staff for toileting needs. Review of the Falls CAA dated 9/10/2015 documented the resident had the following fall risk factors: impaired balance, reduced safety awareness, required assistance during transfers and ambulation, used antidepressant medication, and had a history of falls prior to his/her admission. Fall risk assessments documented the following scores: 8/3/12/2015- 10- no risk. 9/16/2015- 12- fall risk. Review of the care plan dated 8/31/2015 documented the resident was at risk for falls due to weakness following a hysterectomy, was weight bearing as tolerated, used a wheelchair and walker with staff assistance. The resident's risk for falls was low and staff placed no interventions to prevent falls. The resident was incontinent and required assistance of one staff with toileting. The care plan directed staff to assist the resident with toileting, The care plan directed staff to assist the resident with toileting, and as needed. Staff		falls since admission Review of the ADL (A (Care Area Assessmedocumented the reside following a hysterecta assistance of one state of the Urinary 9/10/2015 document assistance with toilet incontinence, a history (the bladder drops do for toileting needs. Review of the Falls C documented the residerisk factors: impaired and ambulation, used and had a history of the admission. Fall risk assessments scores: 8/31/2015- 10- no ris 9/15/2015- 10- no ris 9/16/2015- 12- fall risk review of the care ple documented the resident with toileting as tole and walker with staff risk for falls was low interventions to prevention to prevention of the care ple documented the resident with toileting. The cate assist the resident with toileting. The cate assist the resident with toileting. The cate assist the resident with toileting.	Activities of Daily Living nent) dated 9/10/2015 sident had decreased mostomy and he/she required taff with ADL's. Ty Incontinence CAA data ted the resident required tring, had frequent urinarity of a prolapsed bladded down) and he/she notified town) and he/she notified dassistance during transfed assistance during transfed antidepressant medical falls prior to his/her ts documented the follows k. Sk. Sk. Sk. Splan dated 8/31/2015 sident was at risk for falls ing a hysterectomy, was oblerated, used a wheelch of and staff placed nowent falls. The resident was a trief to the resident was a trief assistance of one start plan directed staff to with toileting upon rising, with toileting upon rising,	bbility ed ded dry er d staff all ety efers ation, wing s due eair ent's was etaff	F 323			

175542 B. WING 09/28/2015	, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	IAME OF PRO	OVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STAT	ΓE, ZIP CODE	•		
ADVANCED HEALTH CARE OF OVERLAND PARK 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207	ADVANCE	ED HEALTH CARE OF	OVERLAND PARK						
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F 323 Continued From page 44 revised the care plan following a fall on 9/15/2015 and direct staff to add a bed alarm and fall mat. Staff revised the care plan on 9/16/2015 following a fall and directed staff to obtain an urinalysis to rule out infection, provide verbal education to the resident on the use of the call light, and assist the resident with toileting upon rising, between meals, and at bectime. Review of a bowel and bladder assessment dated 9/3/2015 documented the resident was incontinent for years and voided 3-4 times a day. Staff were directed to assist the resident with toileting upon rising, before and after meals, and before bed. Review of a fall investigation dated 9/15/2015 documented the resident fell at 11:00 A.M. in his/her room when he/she attempted to put his/her phone back on the hook. Staff placed fall mats at bedside and bed alarms to prevent further falls. The investigation lacked details of where the phone was located in his/her room and when staff last saw the resident. Review of the fall investigation dated 9/16/2015 documented the resident fell at 7/45 A.M. in his/her room. Staff heard the bed alarm sound and found the resident fell at 7/45 A.M. in his/her room. Staff heard the bed alarm sound and found the resident fell revision to the foor mat beside his/her bed with the call light on. The resident reported he/she needed to use the toilet. Staff assisted the resident fell revision and educated him/her to use the call light before getting out of bed. Additional interviews included: check urinalysis and add a toileting schedule. Review of physician orders documented the following: Furosemited. Asix (a medication used to decrease swelling, which increased urine output)	F 323	revised the care plan and direct staff to add Staff revised the care a fall and directed starule out infection, provesident on the use or resident with toileting and at bedtime. Review of a bowel an 9/3/2015 documented incontinent for years a Staff were directed to toileting upon rising, before bed. Review of a fall invest documented the residhis/her room when he his/her phone back or mats at bedside and I further falls. The invest where the phone was when staff last saw the Review of the fall invested to the fall invested to the phone was when staff last saw the Review of the fall invested the resident reported he/s Staff assisted the resident repor	following a fall on 9/15 d a bed alarm and fall no plan on 9/16/2015 following a fift to obtain an urinalysic vide verbal education to fifthe call light, and assicution rising, between resident was and voided 3-4 times at a assist the resident with before and after meals, before and after meals, and the hook. Staff place bed alarms to prevent estigation lacked details a located in his/her roome resident. The stigation dated 9/16/20 dent fell at 7:45 A.M. in eard the bed alarm sount seated on the floor many than the call light on. The she needed to use the ident to the restroom and use the call light before dditional interviews included a toileting schedule orders documented the medication used to	nat. owing is to o the st the meals, dated day. h and 5 n ed fall s of n and 015 und hat e toilet. nd uded: e.	F 323				

NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK (X4) ID PREFIX TAG PREFIX OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 45 20 mg (milligrams) by mouth daily for edema, 9/10/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 45 20 mg (milligrams) by mouth daily for edema, 9/10/2015	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
ADVANCED HEALTH CARE OF OVERLAND PARK 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 45 20 mg (milligrams) by mouth daily for edema,			175542		B. WING		09/28	3/2015
OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 45 20 mg (milligrams) by mouth daily for edema,	NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
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20 mg (milligrams) by mouth daily for edema,	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
During call light checks on 9/16/2015 at 1:30 P.M. the activate bedroom and bathroom call light did not transmit to the CNA (certified nursing assistant) pager system. During an observation on 09/16/2015 at 5:21 P.M. the resident laid in his/her bed, call light within reach, staff placed fall mats on both sides of his/her bed and placed a bed alarm under the sheets. At 5:27 P.M. direct care staff O assisted the resident out of bed using extensive assistance and cued the resident to use his/her walker to transfer from the bed to the wheelchair. Staff assisted the resident to the dining room and falled to offer bathroom assistance. During an observation on 09/17/2015 at 8:01 A.M. staff P provided extensive assistance with standing and limited assistance with walking to the bathroom. The resident's brief was solled and he/she smelled strongly of urine. During an observation on 09/21/2015 at 6:07 A.M. direct care staff Q entered the resident visal signs. Staff Q did not offer to assist the resident with tolleting after he/she woke the trend on the call light both times for staff assistance and no staff came. The resident said the only times he/she attempted to walk by him/herself was to tollet when staff falled to respond to his/her call light. The resident to walk by him/herself was to tollet when staff falled to respond to his/her call light. The resident to the staff	F 323	20 mg (milligrams) by 9/10/2015 During call light check the activate bedroom not transmit to the CN assistant) pager system of the resident laid in his reach, staff placed fall his/her bed and places sheets. At 5:27 P.M. the resident out of be assistance and cued walker to transfer from Staff assisted the resifialed to offer bathroom. During an observation staff P provided extensianding and limited at the bathroom. The reand he/she smelled so During an observation direct care staff Q enturned on lights and to Staff Q did not offer to toileting after he/she when trying to take his The resident stated he when trying to take his The resident staff alled to resident staff failed to resident	ks on 9/16/2015 at 1:30 and bathroom call light NA (certified nursing em. In on 09/16/2015 at 5:22 s/her bed, call light with Il mats on both sides of ed a bed alarm under the direct care staff O assist dusing extensive the resident to use his/method to the dining room of assistance. In on 09/17/2015 at 8:02 is sident to the dining room of assistance with walking esident's brief was soile strongly of urine. In on 09/21/2015 at 6:03 it is sident's room ook the resident's vital to assist the resident with woke the resident. In 09/16/2015 at 5:16 Pershe slid out of bed twiting im/herself to the bathroom of he/she turned on the caff assistance and no side in the only times he/se him/herself was to toile espond to his/her call light in the sident of the t	D P.M. t did 1 P.M. hin f ne isted ther chair. n and 1 A.M. g to ed 7 A.M. hm, signs. th 2.M. ice hom. call taff she et ght.	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 ' '	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		175542		B. WING		09/28	3/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	•	
ADVANCE	D HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
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F 323	, 6			F 323			
	know he/she needed to go to the bathroom.						
	During an interview on 09/21/2015 at 1:47 P.M. the resident stated staff did not routinely assist the resident with toileting until he/she fell.						
	During an interview on 9/16/2015 at 1:35 P.M. direct care staff R stated the pagers did not always work and some call lights came through the pager while others did not. He/she stated when in the dining room or another resident room, he/she was not aware of which call lights came on.		ugh d				
	During an interview on 09/16/2015 at 5:30 P.M. direct care staff O stated the resident did not ask staff for help and experienced falls. Staff O stated he/she was made aware today the call light pagers were not working.						
	During an interview on 09/17/2015 at 11:13 A.M. direct care staff S stated the resident had a risk for falls. Staff S said interventions to prevent falls included the use of fall mats and bed alarms. Staff S was unaware if the resident had falls since he/she admitted and stated the resident was not on a toileting schedule.		risk t falls since				
	During an interview on 09/17/2015 at 2:36 P.M. direct care staff T stated he/she knew the resident was a fall risk because the resident had a bed alarm and floor mats. Staff T stated the resident was continent or urine, used his/her call light for assistance as he/she needed, and was not on a set toileting schedule.		had ne call				
	During an interview 9/21/2015 at 10:30 A.M. direct care staff Q stated the resident was at risk for falls, used a bed and wheelchair alarm, and staff checked on the resident every 2 hours and		risk				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207		
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F 323	asked if he/she needled the resident was not of schedule so he/she 2 hours and when the light. Staff Q stated he answer resident call light. Staff Q stated he answer resident call light. During an interview of licensed nursing staff on a toileting schedule and bedtime, required wore a brief for income resident slipped out of 9/16/2015. Staff H strincluded: urinary urged He/she stated the phyresident's Lasix on 9/17 resident required rem Staff H reviewed the fill 8/31/2015 and reported ambulatory with incorresident scored a 12 and admission. Staff H saresident's fall interver worksheet and/or care determine if a resident program. Staff D state program for every incrising, between meals stated he/she and lice followed up with the re 9/15/2015 fall and detattempted to reach his up the phone. Staff D document findings. He	ed to toilet. Staff Q start on a specific toileting asked about toileting asked about toileting expeciated about toileting expeciated about toileting expeciated about toileting expeciated and the pagights. In 09/21/2015 at 12:17 H stated the resident of a walker to ambulate tinence. Staff H said the feed on 9/15/2015 and atted the risk factors for ency and poor cognition discontinued the 21/2015. Staff H stated inders to use the call lifted in the resident was entinence, which indicate and had a risk for falls aid direct care staff knew the plan. In 09/21/2015 at 6:57 Power of the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the care plant was on a toileting the staff to read the resident has better the staff to read the res	very call ger to P.M. was heals, and he d falls he d the ght. ted ed the con w the CNA A.M. an to he dupon ff D head and	F 323			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
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ADVANCE				DIAN CREE AND PARK,	K PARKWAY KS 66207		
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F 323	when the staff last sar assessment should in personal belongings a stated the resident be 9/16/2015 following h unsure if the resident many falls occurred be He/she stated the fall indicated the call light During an interview of administrator staff A significant system in place for changer system worked Review of the Fall Professional Professional Systems and the system in the facility failed to enassessment, supervising prevent falls for this reextensive staff assistant order sheet dated 9/1 following diagnosis: Interview of Mental Staff Set) dated 9/4/2015 conterview for Mental Staff Review of Mental Staff Review of Mental Staff Set) dated 9/4/2015 conterview for Mental Staff Review of Mental Staff Re	w the resident. Stated include the location of and the phone. Staff Digan a toileting schedul is/her fall. He/she was was incontinent, but kneed a section of the was activated. In 9/16/2015 at 1:43 P.M. Stated there was no polition between the call. In evention Policy dated and the residents were on to determine fall risk terventions. Insure adequate sion and assistance to be sident who required ance. #248's signed physician /2015 documented the hip replacement Island MDS (Minimum Data documented a BIMS (Broth Status) score of 15, whick tion. The resident required of one staff with bed	le on new a ds. 9/16 VI. icy or Il light c and	F 323			
	Review of the ADL CA	AA (Care Area Assessm	nent)				

NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 49 dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement. Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls. Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential		NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
ADVANCED HEALTH CARE OF OVERLAND PARK (X4) ID OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 49 dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement. Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls. Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential		175542			B. WING		09/28	3/2015
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 49 dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement. Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls. Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential	NAME OF PR	ROVIDER OR SUPPLIER STREET AL			ESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 49 dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement. Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls. Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential	ADVANCE	ED HEALTH CARE OF	OVERLAND PARK					
dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement. Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls. Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
benefits and risks included strangling, suffocating, bodily injury, and death when part of the body caught between rails or between the bed rails and mattress. During an observation on 9/16/2015 at 9:03 A.M. a bed cane measured 11 inches by 16 inches was on the left side of the bed. During an observation on 9/16/2015 at 5:59 P.M. the alert and oriented resident used the bed cane to change from a lying to a sitting position in bed with no safety issues observed. During an observation on 09/17/2015 at 7:17 A.M. the alert and oriented resident used the bed cane to change positions in his/her bed safely. During an interview on 09/21/2015 at 1:50 P.M. staff positioned a bed cane on the resident's left side of the bed with no large gaps observed. During an interview on 09/16/2015 at 5:46 P.M. the resident stated he/she asked for a bed cane because he/she felt safer. The resident said a therapist suggested the use of the bed cane he/she found it helpful to get in and out of bed. The resident stated he/she had no problems or	F 323	dated 9/9/2015 docur extensive assistance transfers following a like Review of the resident 8/28/2015 documenter risk for falls. Review of a side rail of resident on 9/1/2015 consented to the usage bed mobility independent benefits and risks inclustificating, bodily injustified the body caught between rails and mattress. During an observation a bed cane measured was on the left side of the alert and oriented to change from a lying with no safety issues. During an observation the alert and oriented to change positions in the alert and oriented to change positioned a bed side of the bed with no the resident stated he because he/she felt stherapist suggested the/she found it helpful	mented the resident reconsist with bed mobility and eft hip replacement. It's care plan dated ed the resident was at I consent form signed by documented the residence. The potential luded strangling, ury, and death when pare en rails or between the consent form signed by 16 inches fithe bed. In on 9/16/2015 at 9:03 at 11 inches by 16 inches fithe bed. In on 9/16/2015 at 5:59 resident used the bed of the strangling position in observed. In on 09/17/2015 at 7:17 resident used the bed in his/her bed safely. In 09/21/2015 at 1:50 Procane on the resident's or large gaps observed and 09/16/2015 at 5:46 Procane of the bed cane all to get in and out of bed in the get in and out of the get in the get in the get in the get in and out of the get in the ge	ow the ent rease art of he bed A.M. es P.M. cane bed 7 A.M. cane 3.M. sleft 4.M. ane da and ed.	F 323			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURY			
		175542		B. WING		09/28	/2015		
	OVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE					
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
F 323	During an interview of direct care staff S stated cane appropriate witnessed safety conductive of stated the resident used buring an interview of licensed nursing staff for residents who need in bed. Staff H stated by therapy after computer of the state o	the use of the bed cane in 09/17/2015 at 11:23 at ted the resident used the ly and he/she had not cerns. In 09/17/2015 at 2:51 P sed the bed cane safely in 09/21/2015 at 3:32 P is stated bed canes we ded help turning thems a bed canes were instal bleting an assessment. In 09/21/2015 at 7:59 P is staff D stated occupate assessment for bed care if the facility did not con intil brought to the facility curvey process. In 09/21/2015 at 7:59 P is staff D stated occupate assessment for bed care if the facility did not con intil brought to the facility curvey process. In 09/21/2015 at 7:59 P is staff D stated occupate assessment for bed care if the facility did not con intil brought to the facility curvey process. In 09/21/2015 at 7:59 P is staff D stated occupate assessment for bed care at the facility did not con intil brought to the facility curvey process.	A.MMMere selves led .M. tional ne sider ty's	F 323					
	The facility failed to ensure the environment remained as free from accident hazards as possible and installed an unsafe bed cane for resident #248's use.								
	483.25(I) DRUG REG UNNECESSARY DR	GIMEN IS FREE FROM UGS		F 329					
	unnecessary drugs. A	regimen must be free fi An unnecessary drug is cessive dose (including for excessive duration;	any						

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DE CORRECTION IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION	(X3) DATE S COMPLE	
	175542			B. WING		09/	28/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ADVANCE	D HEALTH CARE OF	OVERLAND PARK	4700 IN	DIAN CREE	K PARKWAY		
			OVERL	AND PARK,	KS 66207		
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F 329	indications for its use adverse consequence should be reduced or combinations of the reason a compreheresident, the facility may who have not used argiven these drugs untitle the residents and door record; and residents drugs receive gradual behavioral intervention	nitoring; or without adea; or in the presence of es which indicate the do discontinued; or any easons above. ensive assessment of an aust ensure that resider ntipsychotic drugs are reless antipsychotic drug to treat a specific condicumented in the clinical who use antipsychotic I dose reductions, and	ose Ints not	F 329			
	This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview and record review the facility failed to identify and monitor potential adverse effects of black box warning medications for 3 of 5 resident's sample for unnecessary medications, (#4, #93, #242), failed to monitor bowel movements and provide treatment for 1 of 5 resident's sampled for unnecessary medications (#93), and failed to request physician ordered blood pressure parameters prior to withholding blood pressure medications for 2 of 5 resident's sampled for unnecessary medications. (#4, #259)		tions or 1 of sician				
	Findings Included:						

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SUR	
	175542			B. WING		09/25	3/2015
						03/20	5/2013
	OVIDER OR SUPPLIER			RESS, CITY, STA			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	O Continued From page 52			F 329			
	Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnosis: hypertension (elevated blood pressure).						
	Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident 7 days of antianxiety, antidepressant, and diuretic medications during the 7 day observation period.						
	Review of the Psychotropic Drug Use CAA (Care Area Assessment) dated 9/8/2015 documented the resident used antianxiety and antidepressant medications.						
	Review of the care plan dated 9/11/2015 directed staff to administer medications as ordered by the physician. The care plan lacked identification and monitoring of black box warning medications.						
	Review of a pharmacy consultant drug regimen review dated 9/3/2015 documented the clinical record was reviewed and there were no new suggestions.		cal				
	Review of the September 2015 MAR (medication administration record) documented staff held Lisinopril (a medication to treat high blood pressure) on 9/14/2015 and 9/15/2015.						
	· · · · · · · · · · · · · · · · · ·						

	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SU COMPLE			
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NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE					
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 329	8/26/2015 Ferrous Sulfate (an in mouth daily for anem Hydrocodone-Acetan medication) 5-325 m; needed for pain scale every 4 hours as nee effective 8/26/2015 Lisinopril 20 mg, give hypertension, effectiv Lovenox (a medicatic clots) 40 mg/0.4 ml (is subcutaneous daily fo 9/13/2015 Synthroid 150 mcg by hypothyroidism, effective 9/9/2015 During an observation the alert and oriented electric wheelchair and During an observation the alert and oriented electric wheelchair and the resident said he/shed his/her blood prohe/she wanted staff to need to know that too he/she did not have medications. During an interview of direct care staff S stabehaviors communications.	ron supplement) 325 mg ia, effective 8/27/2015 ninophen (a narcotic page by mouth every 4 house of 1-5, give 2 tbs by moded for pain scale of 6-2 40 mg by mouth BID for 8/26/2015 on used to prevent bloomilliliter), give 40 mg or clot prevention, effective 8/26/2015 epressant) 75 mg by mouth daily for citive 8/26/2015 epressant) 75 mg by mouth (inability to sleep on on 09/17/2015 at 9:30 diresident sat in his/her and worked with therapy on on 09/17/2015 at 4:32 diresident worked with y room. In 09/21/2015 at 1:58 Peshe was not aware if states are medication, but on ontify him/her "becauso". The resident stated negative effects from his on 09/17/2015 at 1:21.	ain airs as abouth alo, or d ctive DA.M. A.M. A.M. aff ase I s/her A.M.	F 329					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SUI COMPLET	
	175542			B. WING		09/2	8/2015
	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ADVANCI	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	nursing assistants) do movements and vital vital signs were docur to the charge nurse. During an interview of direct care staff T starstaff documented behavior resident experienced nurse know. During an interview of direct care staff Q saip pressure was more that nurse know immediate the vital sign flow she obtained all the vital sign flow she obtained and the resident. Start held Lisinopril on 9/12 of 117/67 and on 9/13 of 108/49. Staff H collacked documentation notification of blood placked documentation notification of blood placked documentation notification of blood placked documentation notification should be supported by the resident's systopressure number) was diastolic blood pressure number) was diastolic blood pressure number) was diastolic blood pressure sign for the resident's systopressure number) was diastolic blood pressure number) was diastolic blood pressure number) was diastolic blood pressure number.	ocumented bowel signs. He/she said one mented he/she gave the most of the property of the prop	e list .Mare if .a he A.M. he gave aff .M. od .an staff sure sure cord nt rse's d the .Mthe	F 329			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	expected staff to notify physician if a nurse hexpected the nurse to communication. Staff warnings to be identify. Review of the facility condition policy document promptly notified the resident's medical coordinates for this represcribed black box failed to request para	fy the resident and the eld a medication and o document the f D expected black box fied and monitored. Is undated change in mented the facility staff physician of changes in ndition and or status. Identify and monitor was esident with physician warning medications as meters for holding this prescribed blood pressu	n a rning nd	F 329			
	- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: pneumonia (inflammation of the lungs) and hypertension (elevated blood pressure). Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. The resident required limited assistance of one with toileting. The resident received 7 days of antidepressants and 7 days of antibiotic medication during the 7 day observation period. Review of the Psychotropic CAA (Care Area Assessment) dated 9/10/2015 documented the resident received antidepressant medication and staff were to monitor for signs/symptoms of side effects.						

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SUF	
	175542			B. WING		09/28	8/2015
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ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
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F 329	9 Continued From page 56			F 329			
F 329	Review of the care pladocumentation of blad monitoring for medical antidepressant use. altered elimination and administer medication accurate record of bocomplications, and to needed. Review of a pharmace dated 9/3/2015 documented buprofen with form the complex of the MAR (precord) dated 8/31/2015 to 9/1/2016 to 9/1	an dated 8/31/2015 lact ck box warnings, behave ations effectiveness of The resident had a risk in the resident to a sa ordered, keep an awel movements to avoid assist to utilize the toil in the resident should be received administrative of the received no additional regulation. The regulation is the resident in the re	rior for for id et as rould cord he 2015 on onal rad a owing 10 oowel	F 329			
		n on 09/16/2015 at 5:2	1				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SU COMPLE	
	175542			B. WING		09/2	28/2015
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IN	RESS, CITY, STA DIAN CREEI AND PARK,	K PARKWAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	P.M. the resident laid closed, lights out, and During an interview of the resident stated he medications, he/she medication for some effects from his/her medication for some effects from his/her medication since adhe/she told staff and shim/her medication to staff did not. During an interview of direct care staff S said documented bowel medially. During an interview of direct care staff Q staff the mornings and late last bowel movement documented bowel medication in the election of the staff did not. During an interview of direct care staff Q staff the mornings and late last bowel movement documented bowel medication in the election of the staff did nursing assist residents when his/he and document the bostated the nurse also notes if a resident with movement, the nurse Magnesia, if 4 days powement, the nurse Magnesia, if 4 days powement, the nurse	in his/her bed with eyed no signs of restlessned no 9/16/2015 5:43:04 Fe/she was aware of his/received the same time, and had no negathedications. In 09/21/2015 at 1:45 Phe/she experienced mission. The resident staff said they would give treat the constipation, or treat the constipation, or on 09/17/2015 at 11:21 // distaff monitored and novements and vital sign of the day when his/her occurred. Staff Q said novements on the vital stronic record. In 09/21/2015 at 12:43 Fe/she treat the CNA's istants) were to ask the er last bowel movement well movements. He/she documented in the product a days without a bowel movement. Sent 3 days without a bowel movement.	ess. P.M. her tive .M. said we but A.M. ns A.M. ed in er I staff sign P.M. t was ne gress Staff wel	F 329			

NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and staff did not administer Milk STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207 DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 58 F 329 movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and staff did not administer Milk	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				l , ,			B) DATE SURVEY COMPLETED	
ADVANCED HEALTH CARE OF OVERLAND PARK OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 A700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 F 329 MOVEMENT TAG MOVEMENT TA			175542		B. WING		09/2	28/2015	
OVERLAND PARK, KS 66207 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 58 movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 58 movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 F 329	ADVANCE	ED HEALTH CARE OF	OVERLAND PARK						
movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION	
of Magnesia. Staff H confirmed he/she was not aware of black box warning medications, said black box warning medications, said black box warning medications were not specific, and staff did not monitor potential negative effects for this resident. During an interview on 09/21/2015 at 7:23 P.M. administrative nursing staff D said he/she expected nurses and CNA's to document bowel movements. Staff D confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and said the staff failed to administer Milk of Magnesia to the resident on 9/5/2015. Staff D confirmed staff did not care plan or monitor black box warnings. Review of the facility's undated Bowel Brigade policy documented staff administered Milk of Magnesia 30 ml (milliliters) in the morning if the resident did not have a bowel movement for 3 days. The facility failed to provide a Black Box Warning Medication Policy as requested. The facility failed to treat this constipated resident after 3 days without a bowel movement and failed to identify and monitor physician ordered black box warning medications. - Review of resident #259's signed physician order sheet dated 9/15/2015 documented the following diagnoses: chronic obstructive pulmonary disease (chronic poor airlinow in the lungs) and hypertension (elevated blood	F 329	movement, the nurse enema. Staff H conf documented bowel m through 9/5/2015 and of Magnesia. Staff H aware of black box warning me and staff did not monifor this resident. During an interview o administrative nursing expected nurses and movements. Staff D on documented bowe through 9/5/2015 and administer Milk of Ma 9/5/2015. Staff D corplan or monitor black Review of the facility's policy documented st Magnesia 30 ml (milli resident did not have days. The facility failed to p Medication Policy as The facility failed to trafter 3 days without a to identify and monito box warning medication. - Review of residents order sheet dated 9/1 following diagnoses: pulmonary disease (contact of the staff	gave the resident an irmed the resident had lovement from 9/3/2018 I staff did not administe confirmed he/she was arning medications, say edications were not specific potential negative of the confirmed the resident of the confirmed staff failed to gnesia to the resident of the confirmed staff did not can box warnings. Is undated Bowel Brigate aff administered Milk of liters) in the morning if a bowel movement for covide a Black Box Warrequested. It is constipated resident of the confirmed staff and movement and or physician ordered black on the confirmed staff constipated residuals and the confirmed staff constipated residuals and the confirmed staff constipated residuals and the confirmed staff constipated residuals constipated residuals constipated residuals and the confirmed staff constipated residuals constipated residuals constipated residuals constituted the confirmed constitutive confirmed confi	r Milk not iid id icific , effects .M. wel had 015 on re de f the r 3 rning sident failed ick	F 329				

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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NAME OF PR	ROVIDER OR SUPPLIER STREET AI			ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	pressure).			F 329			
	The MDS (Minimum Data Set) or CAA (Care Area Assessment) were not completed because the length of stay criteria was not met.						
	Review of the care plan dated 9/14/2015 revealed staff did not address medications.						
	Review of the September 2015 MAR (medication administration record) documented the following: On 9/17/2015 Coreg 6.25 mg by mouth staff did not administer. Staff documented the resident's blood pressure was low at 109/67.						
	On 9/19/2015 Coreg was held for a blood pressure of 99/62.						
	following: Coreg 6.25 mg (millig	orders documented the					
	with meals for hypertension, effective 9/14/2015 During an observation on 9/17/2015 at 11:35 A.M. the resident sat in his/her recliner. The resident was alert, oriented, and anxious about his/her medications.						
	During an interview on 09/17/2015 at 8:11 A.M. the resident said staff failed to give him/her Coreg.						
	Coreg. During an interview on 09/21/2015 at 2:13 P.M. the resident stated the nurse told him/her on 9/18/2015 that his/her blood pressure ran low and the physician chose to hold the evening dose of Coreg.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
	175542		B. WING		09/2	8/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF	OVERLAND PARK	4700 INI		K PARKWAY		
		OVERL	AND PARK,	KS 66207		
PRÉFIX (EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329 Continued From page	je 60		F 329			
During an interview of direct care staff S sat assistants) obtain an He/she said staff down he/she gave the list. During an interview of direct care staff Q sat pressure was more town from the vital sign flow shook all vital signs. During an interview of licensed nursing staff residents when he/s was not aware if this said the nurse shoul nurse held a medical held the resident's Coblood pressure different staff held blood pressure different staff held blood gress medical record lacked physician notification late administration of holding of blood pressure administrative nursing expected staff to hold if the resident's systom pressure number) we diastolic blood pressure number) we expected staff to not	on 09/17/2015 at 11:21 aid CNA's (certified nursical document vital signs. cumented all the vital signs to the charge nurse. on 09/21/2015 at 10:42 aid if a resident's blood than 110/52, he/she let to tely, otherwise he/she geet to the nurse once stately, otherwise he/she geet to the nurse once stately. On 09/21/2015 at 3:57 Part of H stated he/she informable held a medication are was a facility policy. So do notify the physician if a too. Staff H confirmed force on 9/17/2015 for a 19/67 and held it on 9/19 of 99/62. Staff H said cood pressure medication ure results and confirmed ad documentation of an of blood pressure result for the pressure medication. On 09/21/2015 at 7:54 Part of Documentation of a sure medication. On 09/21/2015 at 7:54 Part of Documentation of the pressure medication. On 09/21/2015 at 7:54 Part of Documentation of the pressure medication. On 09/21/2015 at 7:54 Part of Documentation of the pressure medication.	gns , A.M. he gave aff A.M. hed had taff H a staff a 1/2015 ns for ed the lts, and A.M. ation blood e lt f D se	F 329			

Printed: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/	28/2015
	OVIDER OR SUPPLIER ED HEALTH CARE O	F OVERLAND PARK	4700 IN	RESS, CITY, STA DIAN CREEI AND PARK,	K PARKWAY	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	Review of the facility condition policy docupromptly notified the resident's medical condition policy docupromptly notified the resident's medical conditions this resident prescribed blood preoccasions. Review of resident orders dated 9/1/15 diagnoses: congestic cannot pump enough need) and depressions worthlessness, and Review of the 14 dates (MDS) dated 8/3 Interview for Mental which indicated interview for Mental which indicated interview for Mental which indicated interview for Tobservation period. Review of the Psych Assessment (CAA) or review of the resident met the resident's negive medications as adverse effects. Review of the care pastaff to administer monitor for pain, and medication was not care plan on 9/7/15 mood. The care plan on 19/7/15 mood. The care plan	y's undated change in umented the facility staff a physician of changes in ondition and or status. request parameters for with hypertension physicial documented the following we heart failure (the health blood to meet the body on (feelings of sadness, emptiness). y admission Minimum D 31/15 revealed a Brief Status (BIMS) score of ct cognition. The reside	sician n's ng rt y's ata 15, nt did nt, ly Area d d they d to for ted ne che s le	F 329			

Printed: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	· · · · · · · · · · · · · · · · · · ·			3) DATE SURVEY COMPLETED	
		175542		B. WING		09/:	28/2015
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	or increased depress services as needed. dehydration (not enormedication use and sordered and monitor dehydration. Review of the resider medications included Furosemide (medications included Furosemide (medications) for edema, Sertraline (antidepresonce daily for depressional spironolactone (med body fluid) 25 mg one failure, effective 8/19 Levaquin (antibiotic) for infection, effective During an observation resident sat in his/heatelevision. During an observation the resident sat in a resident was pleasant During an interview of resident stated he/sh medications on time. During an interview of increased nursing staff no behaviors, which is said the resident receded pression and was abox warning medications.	sion, and to offer counse. The resident was at risk ugh body water) due to staff to monitor labs as for signs/symptoms of the following: tion to treat increased bins), give 40 mg once deffective 8/19/2015 sant) 100 mg by mouth sion, effective 8/19/2016 ication to treat increase be daily for congestive 1/2015 500 mg, give 2 tablets of e9/4/2015 in on 9/16/15 at 3:30 P. It room calmly watching on on 9/21/15 at 10:45 A recliner in his/her room. It and cheerful.	ody aily n 5 d neart daily M. the . the nad e/she	F 329			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175542 B. WING 09/28/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK **4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 F 329 Continued From page 63 licensed nursing staff M said the resident had no behaviors and he/she received 4 medications with black warnings and the warnings were in the narcotic book as of today. During an interview on 9/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to care plan and monitor black box warning medications. The facility failed to provide a policy on Black Box Warning Medications as requested. The facility failed to identify and monitor physician prescribed medications for this resident with black box warning medications. F 371 483.35(i) FOOD PROCURE, F 371 SS=F STORE/PREPARE/SERVE - SANITARY The facility must -(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 29 residents. Based on observation and interview the facility failed to distribute food under sanitary conditions in 1 of 1 kitchen for 2 of 4 observation days. Findings Included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 371	During an observation dining staff EE sliced with gloved hands, re salad from the walk in bread loaves, touched gloved hands he/she During an observation dining Staff FF twice gloves. During an interview of dining staff II stated he touch bread when may when assisting resided The facility's Bare Hause of Plastic Gloves documented staff need anytime staff touched.	n on 9/16/2015 at 10:07 vegetables in the kitch trieved tuna and chicken refrigerator, obtained dimenus, and with same handled the bread. In on 9/21/2015 at 5:50 handled bread with soil of the soil of the same handled bread with soil of the same handled bread with soil of the same handled bread staff to the same handwiches and other residents.	en e	F 371				
	drugs and biologicals them under an agree §483.75(h) of this par unlicensed personnel law permits, but only supervision of a license A facility must provide (including procedures acquiring, receiving, or	ide routine and emerge to its residents, or obta- ment described in t. The facility may perr to administer drugs if S under the general sed nurse.	mit State ces ate	F 425				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175542		B. WING	· · · · · · · · · · · · · · · · · · ·	09/2	8/2015
	OVIDER OR SUPPLIER			RESS, CITY, STA			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	Continued From pag	e 65		F 425			
	a licensed pharmacis	loy or obtain the service t who provides consulta provision of pharmacy					
	This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to meet the medication needs for 2 sampled residents. (#258, #262)						
	Findings Included:						
	- Review of resident #262's signed physician order sheet dated 9/14/2015 documented the following diagnosis: diabetes mellitus (when the body could not use glucose, made enough insulin, or respond to the insulin).						
	There were not MDS (Minimum Data Set) and CAA (Care Area Assessment) for this resident due to his/her length of stay in the facility.						
	directed staff to admit prescribed, monitor b provide a bedtime sna signs/symptoms of hy and/or high blood sug	dent had diabetes and nister medications as lood sugars as ordered ack, and monitor for po/hyperglycemia (low					
	Novolog (rapid acting	insulin) 16 units					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28	3/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 425				F 425			
	subcutaneous daily between 7:00 A.M. to 9:00 A.M., effective 9/11/2015 Novolog 12 units subcutaneous daily with lunch,						
	effective 9/11/2015	dataneous dany with la	11011,				
	Novolog 15 units sub- effective 9/11/2015	cutaneous daily with di	nner,				
	staff served the resider resident told staff he/s ate an orange before resident stated he/she ago at 11:40 A.M. Lice	n on 9/15/2015 at 12:36 ent a room tray. The she had a sugar crash staff delivered a tray. e received insulin an hotensed nursing staff Hent's room at 12:39 P.M.	and The our				
	checked the resident' resident's blood suga	s blood sugar. The	. and				
	During an observation on 09/17/2015 at 7:24 A.M. licensed nursing staff K entered the resident's room to check the resident's blood sugar and administer insulin. The resident's blood sugar was 250. Staff K administered insulin in the resident's abdomen at 7:31 A.M. Direct care staff S told the resident someone would return to serve him/her a room tray.		's d ar re				
	the resident stated his he/she should take No before eating. The re experienced episodes sugar due to waiting f administered his/her if for something to tide if	s of sweating with low b	n/her tely blood sked sfast				
		n on 09/17/2015 at 8:26 ivered the resident a ro ange, and coffee.					

	OF DEFICIENCIES F CORRECTION			` '	3) DATE SURVEY COMPLETED		
		175542		B. WING		09/	28/2015
	OVIDER OR SUPPLIER			ESS, CITY, STAT			
ADVANCE	ED HEALTH CARE O	F OVERLAND PARK		DIAN CREEK AND PARK, I	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 67		F 425			
	During an interview direct care staff S st after staff served the room. During an interview dietary staff DD stat in the dining room fi trays. Staff DD repo determine when to g did not communicate who received insulir During an interview licensed nursing state within 15 minutes at expected staff to see within 15 minutes. Toom trays after the dining room and hear resident did not received insulir seed nursing state should eat within 30 administration, but the	on 09/17/2015 7:39 A.M. atted staff served room to be resident's in the dining on 09/21/2015 at 1:39 Pleed staff served the resident and then prepared roomed it was up to nursing give insulin and nursing ewith dietary when a resident meeded a room tray. on 09/17/2015 at 8:31 A.M. atted Novolog workfer administration and herve the resident's breakf Staff K said staff delivered years and staff delivered years are successful to mo 09/21/2015 at 4:12 P.M. atted the resident of minutes of insulin the resident liked the insulance. Staff H said he/she was not sure why the staff H stated the resident of minutes of insulin the resident liked the insulance. Staff H said he/she was not sure why the staff H said he/she was not sure why the staff H stated the resident liked the insulance.	A.M. ents om g to staff sident .M. as e/she ast ed in the ne nin 15				
	administered. Staff ordered for staff to a and 9 A.M., with lun not aware why the b specified with meals	H stated Novolog was administer between 7 A.l ch, and with dinner and preakfast insulin was not s.	was				
	administrative nursing aware of how fast N	on 09/21/2015 at 6:37 P ng staff D said he/she w lovolog worked once D referred to a drug guid	as not				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE S COMPLE	
		175542		B. WING		09/	/28/2015
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IN	RESS, CITY, STA IDIAN CREE AND PARK,	K PARKWAY	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 425	and stated the Novol recommended admir before a meal or imm Staff D said he/she clarifying order regar the morning insulin. nursing staff to make meal, not a snack, wadministration. The facility failed to padministration guidel. The facility failed to ethis insulin depender effective control of his	log worked rapidly and nistration within 15 minumediately following a meaxpected staff to ask for rading administration time. Staff D said he/she expersure the resident receivithin 30 minutes of insulprovide an insulin line policy as requested ensure staff administerent diabetic timely for the	eal. a e of pected ved a lin ed to most	F 425			
SS=E	The drug regimen of reviewed at least one pharmacist. The pharmacist must the attending physici nursing, and these references to the facility reported 19 residents in the second control of the seco	each resident must be ce a month by a license of report any irregularities ian, and the director of eports must be acted up a not met as evidenced by a census of 29 resident ample. Based on	d s to oon. by: s with	F 420			
	pharmacy failed to m recommendations to identification and mo medications for 3 of a		arning				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		175542		B. WING	 	09/2	28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	to monitor and make irregularities for 1 of 5 unnecessary medicat monitor and make recopressure parameters withholding blood pre resident's sampled for (#4, #259) Findings Included: Review of resident #4	recommendations for b 5 resident's sampled for ions (#93), and failed to commendations for bloo related to facility staff ssure medications for 2 r unnecessary medicat	ood ood 2 of 5 ions.	F 428				
	sheet dated 9/2/2015 documented the following diagnosis: hypertension (elevated blood pressure). Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident 7 days of antianxiety, antidepressant, and diuretic medications during the 7 day observation period.							
	Area Assessment) da the resident used anti medications. Review of the care pla staff to administer me physician. The care p monitoring of black bo Review of a pharmac review dated 9/3/2018	otropic Drug Use CAA (ated 9/8/2015 documentianxiety and antidepress an dated 9/11/2015 directions as ordered by colan lacked identification ox warning medications by consultant drug regimes documented the clinical	ected y the n and s.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175542		B. WING		09/28/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	
ADVANCE	D HEALTH CARE O	F OVERLAND PARK	4700 IN	DIAN CREEI	K PARKWAY	
			OVERL	AND PARK,	KS 66207	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 428	Continued From page	ge 70		F 428		
	administration record	mber 2015 MAR (medic d) documented staff held ion to treat high blood 015 and 9/15/2015.				
	8/26/2015 included to orders: Cymbalta (a medicarmg (milligrams), give fibromyalgia (disease 8/26/2015)	n ordered medications the following medication tion to treat depression) a 120 mg by mouth daily e with chronic pain), effection supplement) 325 mg	60 for ective			
	Ferrous Sulfate (an iron supplement) 325 mg by mouth daily for anemia, effective 8/27/2015 Hydrocodone-Acetaminophen (a narcotic pain medication) 5-325 mg by mouth every 4 hours as needed for pain scale of 1-5, give 2 tablets by mouth every 4 hours as needed for pain scale of 6-10, effective 8/26/2015 Lisinopril 20 mg, give 40 mg by mouth BID for					
	hypertension, effective 8/26/2015 Lovenox (a medication used to prevent blood clots) 40 mg/0.4 ml (milliliter), give 40 mg subcutaneous daily for clot prevention, effective 9/13/2015					
	for hypothyroidism (I effective 8/26/2015 Trazodone (an antid	micrograms) by mouth of low thyroid hormone), epressant) 75 mg by mo somnia (inability to sleep	outh			
	the alert and oriente electric wheelchair a During an observation	on on 09/17/2015 at 9:30 d resident sat in his/her and worked with therapy. On on 09/17/2015 at 4:32 d resident worked with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER			ESS, CITY, STA		•		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		I	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From page 71			F 428				
	the resident said he/s held his/her blood pre he/she wanted staff to need to know that too	n 09/21/2015 at 1:58 P she was not aware if sta essure medication, but o notify him/her "becau ". The resident stated regative effects from his	se I					
	During an interview on 09/17/2015 at 11:21 A.M. direct care staff S stated direct care staff communicated behaviors verbally to the charge nurse. Staff S said CNA's (certified nursing assistants) documented bowel movements and vital signs. He/she said once he/she documented vital signs he/she gave the list to the charge nurse.							
	During an interview on 09/17/2015 at 2:49 P.M. direct care staff T stated he/she was not aware if staff documented behaviors. He/she said if a resident experienced behaviors, he/she let the nurse know.		are if					
	direct care staff Q sai pressure was more th nurse know immediat	n 09/21/2015 at 10:42 at d if a resident's blood nan 110/52, he/she let t ely, otherwise he/she get to the nurse once staggns.	he jave					
	licensed nursing staff pressure medications and the nurse notified resident. Staff H cont Lisinopril on 9/14/201 117/67 and on 9/15/2	n 09/21/2015 at 1:04 P H stated staff held blood based on nursing judg I the physician and the firmed nursing staff held 5 for a blood pressure 015 for a blood pressure med the medical recor	od Iment d of re of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	` '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175542		B. WING		09/2	28/2015	
NAME OF PROVIDER OR SUPPLIER			RESS, CITY, STA				
ADVANCED HEALTH CARE C	OF OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
PRÉFIX (EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
notification of blood decision to hold List care plan did not as medications. During an interview administrative nurse expected staff to he if the resident's system pressure number) was expected staff to not physician if a nurse expected the nurse expected the nurse communication. Stand monitor black to buring an interview pharmacy consultated facility for medicatical last visit was on 9/3 was aware black be specify the warning communicated his/1 Staff KK stated he/2 electronic record at staff held blood prephysician's order. Saware there were not pressures. The facility failed to policy as requested. The pharmacy faile recommendations of resident with physicians and medications of resident with physicians and medications of resident with physicians and medications of the pharmacy faile recommendations of resident with physicians and medications of the pharmacy faile recommendations of the pharmacy faile recommendation of the pharmacy faile recommendation of the pharmacy faile recommendation of the pha	ion of physician or resided pressure results and nu inopril. Staff H confirmed dress black box warning on 09/21/2015 at 7:54 Plang staff D said he/she old blood pressure medicated blood pressure (top was less than 100 and the sure result (bottom numbers on the considered. Staff Dotify the resident and the held a medication and to document the aff D expected staff to idea to be a more reviews monthly and held a medication and to a more reviews monthly and held a medication and to a more reviews monthly and held a medications of the said held and held held a medications of the said held and held held and held held and held held held held held held held hel	rse's d the l l l.M. ation blood e per of) entify a.M. ed the ais/her she lid not y. to the aware ut a vices	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28	3/2015
	OVIDER OR SUPPLIER			RESS, CITY, STA			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	make recommendation parameters for holding parameters for holding prescribed blood prescrib	#93's signed physician documented the follow in (elevated blood) which is the following in the ion (elevated blood) documented a BIMS (Brown in the ion) by the following in the ion (elevated blood) by the ion (elevated blood) con MDS (Minimum Darboumented a BIMS (Brown in the ion) documented	order ring ta rief ch The rith iod.	F 428			
	documentation of blamonitoring for medical antidepressant use. altered elimination and medications as order of bowel movements to assist to utilize the Review of a pharmace.	ist drug regimen review mented the resident sho	rior for ter ecord and				

			1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28/2	2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	dated 8/31/2015 to 9/ resident had no bowe through 9/8/2015. Review of the MAR (r record) dated 9/3/201	•	he 2015 on				
	documented the resident received no additional medications for bowel regulation. Review of nursing progress notes dated 9/3/2015 through 9/8/2015 documented the resident had a bowel movement on 9/6/2015. Review of physician orders included the following						
	Review of physician orders included the following medications: Dulcolax (a medication to treat constipation) 10 mg suppository rectally daily as needed for bowel regulation, effective 9/3/2015 Oxycodone/Acetaminophen (a narcotic pain medication) 5-325 mg, give 2 tablets every 4 hours as needed for pain rated a 6-10, effective 8/31/2015						
	P.M. the resident laid closed, lights out, and	n on 09/16/2015 at 5:2 in his/her bed with eye I no signs of restlessne	es ess.				
	the resident stated he medications, he/she r	time, and had no nega	her				
	the resident reported constipation since add he/she told staff and s	n 09/21/2015 at 1:45 P he/she experienced mission. The resident s staff said they would give treat the constipation,	said ve				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28	3/2015
	OVIDER OR SUPPLIER			RESS, CITY, STA			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page	e 75		F 428			
	direct care staff S said documented bowel m daily. During an interview o direct care staff Q stathe mornings and late last bowel movement documented bowel m	n 09/21/2015 at 10:36 / ted residents were ask er in the day when his/h occurred. Staff Q said novements on the vital	ns A.M. ed in er I staff				
	buring an interview on 09/21/2015 at 12:43 P.M. licensed nursing staff H stated the CNA's (certified nursing assistants) were to ask the residents when his/her last bowel movement was and document the bowel movements. He/she stated the nurse also documented in the progress notes if a resident had a bowel movement. Staff H said if a resident went 3 days without a bowel		t was ne gress Staff				
	movement, the nurse Suppository, and if 5 movement, the nurse enema. Staff H conf documented bowel m through 9/5/2015 and of Magnesia. Staff H aware of black box warning me	assed without a bowel administered a Dulcola days passed with no bo	no 5 r Milk not iid ecific,				
	administrative nursing expected nurses and movements. Staff D	n 09/21/2015 at 7:23 P g staff D said he/she CNA's to document bo confirmed the resident el movement from 9/3/2	wel had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA	,			
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREE! AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 428	through 9/5/2015 and administer Milk of Ma 9/5/2015. Staff D corplan or monitor black During an interview opharmacy consultant facility for medication last visit was on 9/3/2 was aware black box specify the warnings a communicated his/he Staff KK stated he/shelectronic record at the staff held blood press physician's order and constipation. Staff KK there were no paramed. The facility failed to policy as requested. The pharmacy failed is recommendations to a constipated resident a make recommendation ordered blasses.	I said the staff failed to gnesia to the resident of the resident of the staff did not can box warnings. In 9/24/2015 at 10:51 A KK stated he/she visite reviews monthly and he/o15. Staff KK said he/swarning medications did and he/she verbally or concerns to the facility or concerns to the facility and was not a sure medications without failed to treat for K said he/she was award the facility for this and failed to monitor and make the facility for this and failed to monitor and make the faciled to monitor and make the facility for this and failed to monitor and make the faciled to monitor and make	.M. ed the is/her she id not y. to the aware ut a re es. vices	F 428				
	order sheet dated 9/1 following diagnoses:	5/2015 documented the chronic obstructive chronic poor airflow in the	e					
	(Care Area Assessme	Data Set) and the CAA ent) were not completed f stay criteria was not m						

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/28	3/2015	
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IND	DRESS, CITY, STATE, ZIP CODE INDIAN CREEK PARKWAY RLAND PARK, KS 66207				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 77		F 428				
	Review of the Septem administration record) On 9/17/2015 Coreg 6.25 mg by mo	an dated 9/14/2015 rev medications. The resident staff did not admini- e resident's blood press	ation wing: ister.					
	On 9/19/2015 Coreg for a blood presthe medication.	ssure of 99/62, staff he	eld					
	following: Coreg 6.25 mg (millig	orders documented the grams) by mouth twice of ension, effective 9/14/2	daily					
	the resident sat in his	n on 9/17/2015 at 11:35 /her recliner. The resion nd anxious about his/he	dent					
	_	n 09/17/2015 at 8:11 A failed to give him/her	.M.					
	the resident stated the 9/18/2015 that his/her	n 09/21/2015 at 2:13 P e nurse told him/her on r blood pressure ran lov o hold the evening dose	w and					
	direct care staff S said assistants) obtain and	n 09/17/2015 at 11:21 of CNA's (certified nursing document vital signs). Unented all the vital signs.	ing					

i, ,		, ,	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175542		B. WING		09/28/2015			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLE	ETION		
F 428	Continued From pag	e 78		F 428					
	he/she gave the list to	the charge nurse.							
	direct care staff Q sai pressure was more the nurse know immediat	n 09/21/2015 at 10:42 at d if a resident's blood han 110/52, he/she let thely, otherwise he/she goet to the nurse once state	he jave						
	licensed nursing staff residents when he/sh was not aware if this said the nurse should nurse held a medicati held the resident's Coblood pressure of 100 for a blood pressure of different staff held blood different blood pressumedical record lacked physician notification	ood pressure medication are results and confirmed d documentation of of blood pressure result breathing treatments, a	ned d taff H a staff /2015 ns for ed the						
	administrative nursing expected staff to hold if the resident's systol pressure number) wa diastolic blood pressure number) wa expected staff to notif held a medication and document the community of the properties of the propert	blood pressure medicalic blood pressure (top los less than 100 and the lare result (bottom blood s not considered. Staffy the physician if a nurse to dexpected the nurse to	ation blood e f D se o .M.						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		175542		B. WING	 	09/2	28/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	<u> </u>	
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	was aware black box specify the warnings communicated his/he Staff KK stated he/sh electronic record at the staff held blood pressiphysician's order. Staware there were no pressures. The facility failed to policy as requested. The pharmacy failed recommendations to pressure parameters with hypertension phoressure medication of the state of	warning medications dependent of the facility and was not a sure medications without aff KK said he/she was parameters for blood and holding of this resinysician prescribed blood on 2 occasions. #242's signed physician documented the following the heart failure (the heart failure) (th	y. to the aware ut a vices dent od n's ng rt y's ata 15, nt did nt, ly Area d d they d to	F 428			

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175542		B. WING		09/2	8/2015	
	OVIDER OR SUPPLIER	0/55/ 4/15 545/		RESS, CITY, STA				
ADVANCE	ED HEALTH CARE OF	OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	adverse effects. Review of the care pl staff to administer me monitor for pain, and medication was not e care plan on 9/7/15 to mood. The care plan reassurance and sup or increased depress services as needed. dehydration (not enounedication use and sordered and monitor dehydration. Review of the resider medications included Furosemide/Lasix (m body fluid) 20 mg (mi daily by mouth for edsertaline (antidepressonce daily for depresses Spironolactone (medibody fluid) 25 mg one failure, effective 8/19/Levaquin (antibiotic) for infection, effective Review of a pharmace recorded no recommendation. During an observation resident sat in his/her television.	an dated 8/19/15 direct edications as ordered, notify the physician if the ffective. Staff revised to address the resident's directed staff to provide port, monitor for withdration, and to offer counse. The resident was at risk augh body water) due to taff to monitor labs as for signs/symptoms of at's physician ordered the following: edication to treat increating ligrams), give 40 mg or ema, effective 8/19/201 cation to treat increase the daily for congestive here daily for congestive here.	ne he se e awal eling of for seed noce 15 n 5 d d neart daily	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE		
		175542		B. WING		09/	28/2015	
	OVIDER OR SUPPLIER ED HEALTH CARE OF	OVERLAND PARK	4700 IN	INDIAN CREEK PARKWAY RLAND PARK, KS 66207				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	During an interview oresident stated he/shemedications on time. During an interview or licensed nursing staff no behaviors, which resident recedepression and was abox warning medication box warning medication. During an interview or licensed nursing staff behaviors and he/shewith black warnings an anarcotic book as of to buring an interview or administrative nursing expected staff to carewarning medications. The facility failed to propose a requested. The pharmacy failed warning medication at to the facility for this represcribed black box 483.65 INFECTION CONTRIBENS. The facility must estall infection Control Progressions and to the facility must estalling the proposed in the stalling transport of the sta	n 9/21/15 at 10:45 A.M e received his/her n 9/21/15 at 2:09 P.M. H stated the resident had required redirection. He sived a medication for unaware of any other bons (high risk medication of the management of the warnings were in the plan and monitor black box and make recommendate and the warnings were in the plan and monitor black box and make recommendate and maintain an gram designed to provide and maintain an gram designed to provide and infection.	nad e/she lack ons). d no s n the M. k box vice	F 441				
		blish an Infection Contr	ol					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		175542		B. WING		09/28/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
ADVANCE	ED HEALTH CARE O	F OVERLAND PARK		DIAN CREEI AND PARK,	K PARKWAY KS 66207		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Program under whice (1) Investigates, cor in the facility; (2) Decides what proshould be applied to (3) Maintains a reconstruction actions related to in (b) Preventing Spree (1) When the Infection determines that a reprevent the spread isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hand washing is independent of the professional practice (c) Linens Personnel must hand transport linens so a infection. This Requirement in The facility reported Based on observating failed to properly clearly deprovide a sanitary experience.	ch it - introls, and prevents infections, and prevents infection an individual resident; and of incidents and correspond of incidents and correspond on Control Program esident needs isolation to of infection, the facility may prohibit employees with ase or infected skin lesion with residents or their focus ansmit the disease. It require staff to wash the rect resident contact for validations in the disease of the contact for validations and the contact for validations and preventions.	ion, and ective a oust a ons od, if eir which of	F 441			
	Findings Included:						

175542 B. WING 09/28/2	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ADVANCED HEALTH CARE OF OVERLAND PARK 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 Continued From page 83 F 441	
- During an observation on 9/17/2015 at 12:39 P.M. housekeeping staff Z stated he/she was not aware of the specific isolation precautions for the room he/she cleaned. At 1:39 P.M. staff Z sprayed the bathroom floor with disinfectant cleaner and immediately wiped the floor using his/her foot and a dry cloth. During an interview on 9/17/2015 at 1:42 P.M. housekeeping staff Z stated he/she was not aware how long the disinfectant should remain on the floor before wiping. During an review of the disinfectant bottle, the label revealed the staff should spray the surface until completely wet and let stand for one minute, wipe with a clean cloth, damp cloth, or paper towel or allow to air dry. During an interview on 9/17/2015 at 1:53 P.M. administrative staff A stated he/she expected staff to follow the manufacturer's instructions. Review of the facility's undated Contact Precautions policy documented in addition to Standard precautions, the facility used Contact Precautions for specific residents known or suspected to be infected. The facility failed to follow manufacturer recommendations to clean the room of a resident on contact Isolations precautions.	